Harmonized Guidelines for the Administration, Disbursement, Monitoring and Fund Management of the Basic Healthcare Provision Fund

Federal Ministry of Health (FMOH), National Health Insurance Scheme (NHIS) and the National Primary Health Care Development Agency (NPHCDA)

December 2016

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ACKNOWLEDGEMENT

This guideline for the Administration, disbursement, accessing, utilization, monitoring and overall management of the Basic Healthcare Provision funds has been developed following an extensive consultation and consensus building with stakeholders in the health sector at all levels. These Stakeholders include but not limited to; Government Ministries, National Council on Health, Departments and Agencies, the National Assembly, the States Ministries of Health and the FCT Department of Health Services, Academia, Public Health Experts, Civil Societies, Representatives of Consumer groups and Development Partners. The leadership of the Federal Ministry of Health and indeed all Nigerians who will benefit from the implementation of the provisions of this guideline will for a long time remain grateful to the representatives of all the organizations that contributed selflessly to the development of the guidelines through their technical inputs and financial support.

We remain indebted to members of the Health Financing Technical Working Group, the Basic Healthcare Provision subcommittee and development partners who worked assiduously to develop the initial draft of this guideline and the Ministerial Universal Health Coverage adhoc Committee comprising of the FMOH, NHIS and NPHCDA that worked until the finalization of this guideline. Sincere appreciation goes to the State Commissioners of Health and representatives of the Civil Societies group for their intellectual and constructive inputs.

Our sincere appreciation also goes to the members of the Secretariat who worked assiduously and selflessly to put together all the suggestions and contributions from the reviews by various stakeholders.

Lastly, we sincerely express our profound gratitude to the leadership of the Federal Ministry of Health; Honorable Minister of Health, Professor Isaac F. Adewole for his leadership, the Honorable Minister of State for Health, Dr. Osagie Ehanire for his warm support and intellectual articulations and the Permanent Secretary, Mrs. Binta Bello for her guidance and support without which we would not have been able to finalize this document.

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December, 2016

FOREWORD

With a global push for sustainable development and a convergence of thoughts on the need for countries to move towards achieving Universal Health Coverage (UHC) by the year 2030, Nigeria is committed to increasing access and use of good quality basic health care services and reducing out of pocket expenditure on health.

The compelling need for health systems reform and decades of advocacy to re-awaken government's responsiveness to the health needs of the people culminated in the enactment of the National Health Act in 2014. The Act provides a legal framework for the provision of health care services and establishes an organizational and management structure for the health system in Nigeria. To achieve this important objective of providing quality healthcare services to all Nigerians, the Act specifies that all Nigerians shall be entitled to a Basic Minimum Package of Health Services (BMPHS).

The Basic Health Care Provision Fund (BHCPF), which was established under Section 11 of the National Health Act, creates the fiscal space for funding the BMPHS. The BHCPF would be financed from:

(a) Federal Government Annual Grant of not less than 1% of Consolidated Revenue Fund
(b) Grants from International Partners
(c) Funds from any other source

To ensure judicious use of the funds, the BHCPF guidelines have been developed. The Guidelines define the basis for Administration, Disbursement, Monitoring and Financial Management of the BHCPF. They set out the processes to be applied and the responsibilities of various stakeholders. The BHCPF will: (i) pay for BMPHS through the NHIS; (ii) provide operating budgets to PHC centers (PHCC's) via electronic transfer; and (iii) set aside a small portion for dealing with emergencies, including disease outbreaks and road traffic accidents.

A management secretariat that comprises representatives of a diverse set of stakeholders including states, civil society, private providers, development partners, National Health Insurance Scheme, and National Primary Health Care Development Agency will provide oversight for the BHCPF.

These guidelines have been painstakingly articulated and employ innovative public and private sector led processes. I have the strong conviction that results from the successful implementation of the provisions of the guidelines will no doubt set Nigeria on track towards accelerating Universal Health Coverage. This document will be regularly reviewed in line with emerging clinical and fiscal developments including best practices that will emerge from its implementation. It is therefore my desire that all actors in the health sector adequately support the implementation of the guidelines for the benefit of every Nigerian.

I therefore recommend the guidelines to all stakeholders for appropriate Implementation of the Basic Healthcare Provision Fund.

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Honorable Minister of Health
January, 2017

ABBREVIATIONS

ADMFM	Administration, Disbursement, Monitoring and Financial Management
BHCPF	Basic Health Care Provision Fund
BMPHS	Basic Minimum Package of Health Services
CFFI	Counterpart Fiscal Funding Instrument
DFAAR	Decentralised Financing for Accountability and Results
DFF	Decentralized Facility Financing
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
HMH	Honourable Minister of Health
LGAT	Local Government Authority
LGA	Local Government Area
M&E	Monitoring and Evaluation
MOU	Memorandum of Understanding
NHA	National Health Act
NHIS	National Health Insurance Scheme
NCH	National Council on Health
NPHCDA	National Primary Health Care Development Agency
PHC	Primary Health Care
RBF	Results Based Financing
SFA	State Fund Administrator
SHC	Secondary Health Care
SPHDCA	State Primary Health Care Development Agency
SBHCPF-TF	Basic Health Care Provision Fund-Taskforce
SSHIS	State Supported Health Insurance Scheme
TMSoF	The Management Secretariat of the Fund
TSA	Treasury Single Account
UHC	Universal Health Coverage
CSOs	Civil Society Organisations
FEC	Federal Executive Council
OAGF	Office of the Accountant General of the Federation
FMB&NP	Federal Ministry of Budget & National Planning
CRF	Consolidated Revenue Fund
PHCUOR	Primary Health Care Under One Roof
SIMs	Scene Incident Managers
WDC	World Development Committee
CPD	Continuous Professional Development
NEMA	National Emergency Management Agency
IE	Impact Evaluation

DEFINITIONS

Actuary: a statistician who calculates risks and probabilities for a payment plan.

Administrative Charge: amount set aside to run the operations of the NHIS and NPHCDA Gateways which shall not exceed 10% of the BHCPF.

Affordability: the ability to pay for health services so people do not suffer financial hardship when using them. This can be achieved in a variety of ways including access to essential medicines and technologies to diagnose and treat medical problems, sufficient capacity of well-trained, motivated health workers to provide the services to meet patients' needs based on the best available evidence.

Benefit: this means a benefit or advantage of any kind derived from a Scheme.

Capitation: A payment method in which all providers in the payment system are paid, in advance, whether the enrolee uses the services or not, a predetermined fixed rate to provide a defined set of services for each individual enrolled with the provider for a fixed period.

Catastrophic Spending (for each individual/household): occurs when hospitalisation spending for that person/household as a proportion of ability to pay (household consumption spending less combined survival income for all household members) exceeds a certain threshold.

Civil Society Organisations (CSO): The multitude of associations (usually Non-Governmental Organisations- NGOs and institutions) that reflect and represent the interests and will of citizens through advocacy.

Community Based Health Insurance Scheme (CBHIS): a form of voluntary, not-for-profit insurance mechanism that often involves some form of community management. CBHIS schemes are typically based on a collective entity defined by geographic, professional, or religious affiliations.

Conditional Cash Transfers (CCT): monetary transfers to households on the condition that they comply with pre-defined requirements.

Cost Effectiveness Analysis (CEA): the economic cost of a health intervention is divided by an estimate of the health effects; the interventions with the smallest ratios are considered to be the most cost-effective. CEA is a tool for identifying which health interventions achieve the greatest level of health impact per unit of investment, and the results can be used to evaluate on-going health interventions or to plan for future health programs.

Decentralised Financing for Accountability and Results (DFAAR): A two-way process of increasing facility level autonomy around decisions for expenditure, whilst demanding for increased accountability of service and financial management.

Electronic Medical Records: Digital version of a paper record that contains all of a patient's medical history with the health care provider including diagnosis, treatment and medical services rendered.

Enrolee: An eligible person who is enrolled in a health insurance scheme health plan or the eligible person's qualifying dependant.

Faith Based Organisation: public or private organisation consisting of individuals united on the basis of religious or spiritual beliefs and directing their efforts toward meeting the spiritual, social, and cultural needs of the members of their community.

Fee-for-service (FFS): A payment model for service's' rendered to an enrolee by a health care provider for health services not classified under capitation.

Financial Catastrophe: High out-of-pocket payments for health services in the presence of low household financial capacity and an absence of prepayment mechanisms results in financial catastrophe. This high expenditure for health care results in households or individuals reducing or becoming unable to pay for necessities like food, clothing and even education of children

Fiscal Space: The availability of budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of a government's financial position. Usually, in creating fiscal space, additional resources can be made available for some form of meritorious government spending.

General Government Expenditure on Health: The sum of outlays by government entities to purchase health care services and goods. It comprises the outlays on health by all levels of government, social security agencies and direct expenditure by parastatals and public firms. Besides domestic funds, it also includes external resources passing through the government as grants or loans, channelled through the national budget.

General Government Expenditure: This is the total amount expended by a government and is a reflection of the total expenditure that the government needs to finance from revenues generated such as taxes, economic income and borrowed funds. Current government expenditure includes purchasing goods and services, wage bill, national defence, security and health.

Gross Domestic Product per Capita: Gross domestic product divided by the mid-year population. GDP is the sum of gross value of all resident producers in the economy plus any product taxes and minus any subsidies not included in the value of products. It is calculated without making deductions for depreciation of fabricated assets or for depletion and degradation of natural resources.

Health Care Provider: these are any government or private health care facilities, hospital, maternity centre, community pharmacies and all other service providers, accredited for the provision of prescribed health services for insured persons and their dependents.

Health Maintenance Organisation (HMO): A limited liability company formed by private or public establishments or individuals, to facilitate the provision of preventive and other health care services to a defined group of enrolees and financed by pre-paid employer-employee insurance premium payments. Care is provided by participating health providers and all parties are bound by agreements.

Independent Verification Agent (IVA): An entity whose function is to ensure that only verified outputs are reimbursed, through (a) certifying that the contractual outputs, as reported by the service provider, have been physically delivered and that pre-agreed standards of service have been achieved, and (b) validating the service provider's reimbursement request (performing cost reconciliation by multiplying the quantity of outputs achieved by their unit cost), and recommending to the funding entity to honour payment.

Local Government: Public administration at local level exercised through representative councils established by law, exercising specific powers within a defined geographical area. These powers give the Local Government substantial control over local affairs as well as the staff to direct the provision of services and implement projects, which complement the activities of the State and Federal Governments.

Medical Documents: These include all prescriptions, laboratory forms, excuse duty, death certificate and other documents used in the management of patients.

Medical Practitioner: A person with a medical related degree registerable with the Medical and Dental Council of Nigeria.

Mutual Health Association: A privately or publicly incorporated non-profit organisation formed on the basis of solidarity and collective pooling of health risk by community members and governed by the constitution/bylaws. Run by a Board of Trustees (BoT) elected by members while members take part in its management.

National Health Insurance Scheme (NHIS): The social health insurance scheme in Nigeria established by the National Health Insurance Scheme Act of 1999 of the Federal Republic of Nigeria Laws No. 42 VOL II 2004.

Per Diem: A method of reimbursing a health provider based on a fixed rate per day rather than on actual charges. It is usually uniform irrespective of degree of care.

Pooling: The accumulation and management of revenues so that members of the pool share collective health risks, thereby protecting individual pool members from large, unpredictable health expenditures.

Primary-Level Facility: Typically staffed by general practitioners and/or nurses with limited laboratory services for general but not for specialised pathological analysis; bed size ranging from 0-20 beds; often referred to as first level referral.

Private Expenditure on Health: This includes direct household (out-of-pocket) payments, private insurance, charitable donations, and direct service payments by private corporations.

Provider Payment Mechanism: The mechanisms used to transfer payments for services rendered from the purchaser or a proxy to the health care provider. The Provider Payment Mechanism accomplishes far more than simply the transfer of funds to cover the costs of services.

Public Private Partnership (PPP or P3): A legally-binding contract between government and the private sector for the provision of assets and the delivery of services that allocates responsibilities and business risks among the various partners. The goal is to combine the best capabilities of the public and private sectors for mutual benefit.

Secondary-Level Healthcare Facility: Highly differentiated by function with five to ten clinical specialities; bed size ranging from 20-100 beds; often referred to as Specialist Hospital.

Social Health Insurance Scheme: A health insurance scheme provided by government to its citizens, especially to low and middle-income populations.

Specialist Care: This is care provided by secondary-level healthcare facilities**.** Such care focuses on specific organs or diseases (cardiology, neurology, oncology etc.) including special diagnostic and therapeutic services such as biopsy or dialysis.

Strategic Purchasing: This is the effective allocation of financial resources to providers to enhance health system performance. Specifically, it considers:

- Which interventions to be purchased in response to population needs and wishes, taking into account national health priorities and evidence on cost-effectiveness
- How they should be purchased, including contractual mechanisms and payment systems.

- From whom they ought to be purchased in light of providers' relative levels of quality and efficiency.

Tertiary-Level Healthcare Facility: Highly specialised staff and technical equipment, (Cardiology, Intensive Care Unit ICU and specialised imaging units); clinical services are highly differentiated by function; might have teaching activities; bed size ranging from 100-800 beds; often referred to as Teaching or Tertiary level hospital.

Third Party Administrator: This is either a For-Profit or Not for Profit organisation with expertise and capability to administer all or a portion of the insurance claims process. They are usually contracted to also administer services including claims administration, premium collection, enrolment and other administrative activities.

Total Expenditure on Health: The sum of public and private health expenditure that covers the provision of health services (preventive and curative), family planning services, nutrition activities and emergency aid designated for health.

Universal Health Coverage: A process that ensures all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services.

User Fees: Charges levied on any aspect of health services at the point of delivery.

Vulnerable: This refers to the following categories of people (a) pregnant women, (b) children under five (5) years (c) the elderly >85 years, (d) the disabled, (e) the poor (to be) and others falling within the group.

EXECUTIVE SUMMARY

These set of Guidelines define the basis for Administration, Disbursement, Monitoring and Financial Management (ADMFM) of the Basic Healthcare Provision Fund (BHCPF, "The Health Care Fund"). They set out the processes to be applied, the responsibilities of various stakeholders including (but not limited to) participating healthcare providers, healthcare facilities, Federal Government parastatals [National Health Insurance Scheme (NHIS), National Primary Care Development Agency (NPHCDA), Federal Road Safety Corps (FRSC), National Emergency Management Agency (NEMA, Nigeria Police Force (NPF)]; State Governments, Local Governments and their participating agencies including State Primary Health Care Development Agencies (SPHCDAs) and the accompanying accountability expectations contingent on these responsibilities.

Guidelines ensure the Fund supports current health priorities

These Guidelines have been drawn up to fit the framework stipulated in the National Health Act (NHAct) 2014. It is in alignment with the national health policy, takes into consideration, directives from the leadership of the Health sector, and follows wide-ranging consultations with all relevant stakeholders in the Nigerian healthcare sector. In particular, the Guidelines address urgent interventions put in place to tackle persistent and emerging causes of population mortality in Nigeria including Maternal Mortality, Perinatal Mortality, Road Traffic Injuries (RTIs) and other public health emergencies. They define the minimum performance standards stakeholders are expected to adopt, implement and comply with to meet stipulations set out in these Guidelines. They also provide a framework for realising the strategic objective of the health sector and is consistent with the broader goal of achieving Universal Health Coverage (UHC) for all Nigerians.

Fund guarantees equity and access for improved outcomes

The overriding objective in the development of these Guidelines was ensuring efficient disbursement of the Fund to services, which catalyse improved health outcomes. This will be achieved, initially (in the first five years) through the targeting of specific areas of concern including Maternal and child Health and selected Non-Communicable Diseases (NCDs), Road Traffic Injuries (RTIs) and other public health emergencies. Emphasis was also on the ease and speed of implementation, safeguarding quality in health service delivery as well as entrenching a robust accountability and probity framework, to guarantee prudent financial management of public funds.

Disbursements from the Fund will be through three (3) "Gateways"

As specified in the National Health Act 2014, the Fund will be utilised primarily for three purposes:

i. To pay for provision of the Basic Minimum Package of Health Services (BMPHS) as defined;
ii. To fund operational expenses of Primary Healthcare Centres (PHCs) across Nigeria;
iii. To fund the provision of basic Emergency Medical Treatment and public health emergencies. The former initially targeted at care for Road Traffic Injuries (RTIs), arising from "accident hot-spots" across Nigeria, whilst the latter would be utilized by the Nigeria Centre for Disease Control NCDC to address acute epidemics of public health concerns.

The process conduits through, which disbursement and claims are funded have been designed in line with the provisions of National Health Act 2014. The "NHIS Gateway", is the pathway by which 50% of the BHCPF will be disbursed. The Provider Payment Mechanism for this process is a capitation or modified fee-for-service route. The other pathway through which 45% of the Fund will be disbursed is known as the "NPHCDA Gateway" which will utilise the Provider Payment Mechanism, which is

known as “Decentralised Financing for Accountability and Results (DFAAR)”. All payments shall be made on a monthly or quarterly basis, subject to the SFA and TMSOF receiving monitoring and quality assurance data. The “Emergency Medical Treatment Gateway” is the pathway through which 5% of the BHCPF shall be set aside to provide for Emergency Medical Treatment and public health emergencies. The 5% will be disbursed through a mechanism similar to the NHIS Gateway and through the NCDC. All payments shall be made on a monthly or quarterly basis, in arrears, subject to approval of The Management Secretariat of The Fund (TMSOF) on receipt of monitoring and quality assurance data.

Approach to the NHIS Gateway – Funded basic minimum package anchored on free maternal healthcare.

The NHIS Gateway is intended to establish a system, which facilitates the expansion of the Basic Minimum Package of Health Services (BMPHS) as Government revenues increase. The Basic Minimum Package of Health Services for Nigeria as of 2016 will consist of nine (9) interventions in total; four (4) for aspects of Maternal Health (ANC, Labour and Delivery Care, Emergency Obstetric and Neonatal Care and Caesarean Section) two (2) for children (curative care and immunization), two for Non-Communicable Diseases (Hypertension and Diabetes) and malaria treatment. There is a challenging economic climate in Nigeria and for 2016, the Fund will only amount to about ₦225 per capita. Health resources are always finite and no government can provide all health services to meet all the needs of its population. In essence, choices have to be made. The huge impact of maternal morbidity and mortality on the disease burden in Nigeria has necessitated prioritisation of cost-effective interventions to reduce maternal mortality. This is the cornerstone of the basic package of services and will be delivered in rural areas of Nigeria. Routine immunisation of children remains a key challenge and is now exacerbated with recent limits on funding by donors. The Fund will thus be used in filling some of the gaps in the fiscal space for immunisation.

Approach to the NPHCDA gateway – Key Stakeholders include State Governments and their Agencies

The National Health Act 2014 confers specific responsibilities on public-sector agencies to fulfil certain functions in administration of the Fund. The Guidelines stipulate the precise roles and duties of these key public-sector bodies. State Ministries of Health (SMoH) provide leadership at the State level and ensure successful implementation of the initiative in each State. The Commissioner of Health will appoint the “State Fund Administrator” (SFA) as well as ensure there is a fully functional State Primary Healthcare Development Agency (SPHCDA). For a defined period of five (5) years commencing after approval of these Guidelines, each State shall make annual budgetary provisions for operational expenses in Primary Healthcare Centres (PHC), which shall be reflected in the annual SPHCDA budget. Each participating State Government (and the FCT), through its SPHCDA shall sign a Memorandum of Understanding (MoU) with The Management Secretariat of the Health Care Fund (TMSOF) to govern its participation in the initiative, including estimated amounts allocated for disbursement, reporting obligations, service-level agreements (SLAs) and reporting requirements. The NPHCDA Gateway will entail direct electronic transfer of funds from the CBN account to designated accounts of the SPHCDAs (who serve as “pass-throughs”) for onward transfer to the bank accounts of individual health facilities so that these facilities have the resources needed to meet their operating requirements. The health facility in-charge and the chair of the Ward Development Committee will control the funds. The health facilities will enjoy substantial autonomy in how they use the funds so long as they are used to strengthen the delivery of primary health care (PHC).

Approach to the Emergency Medical Treatment (EMT) Gateway – Key Stakeholders in providing basic care for Road Traffic Injuries (RTIs)

The National Health Act 2014 stipulates that five (5%) per cent of the Fund shall be used to provide Emergency Medical Treatment (EMT) to all Nigerians. The responsibility for administration of this portion of the Fund is vested in a Committee [the Emergency Medical Treatment Committee (EMTC)], which will be the TMSOF. Emergency Medical Treatment (EMT) covers a spectrum of activities including (a) Pre-Hospital Care & Transport (b) Initial Evaluation (c) Resuscitation and (d) In-Hospital Care. In this context, Emergency Medical Treatment (EMT) will apply to, Surgical Emergencies related to road traffic accidents.

For purposes of these guidelines and the operation of the 5% gateway, the TMSOF is the EMTC.

The Management Secretariat shall manage the Health Care Fund

In the National Health Act 2014, the Minister of Health is given responsibility for providing stewardship, ensuring good governance and safeguarding fiduciary prudence. The Minister will appoint the members of the Management Secretariat (TMSOF), which will provide the oversight on the implementation of the Fund on behalf of the Minister. The National Council Health (NCH) will have the power to ratify (or not) the members of the TMSOF. The role of the TMSOF will include: (i) recruitment, appointments, and management of independent verification agents and auditors; (ii) authorizing payments to States and third party administrators; (iii) approving and standardizing service level agreements; (iv) providing redress for providers, patients or communities who have complaints about the implementation of the fund, etc. The TMSOF shall also ensure that Administrative Expenses and Costs for all aspects of implementation of the Fund, do not exceed the set ceiling of five (5%) percent of the Fund.

Guidelines employ innovative, public and private sector-led processes

The Management Secretariat will make payments, for care delivered, to all (both public and private sector) accredited providers, in all States (and FCT) of the Federation. Independent verification of utilisation of services would be conducted through Independent Verification Agents (IVAs) using random samples and customer surveys, both from a central call centre and also through home visits. Periodic random samples will be interviewed to verify that care given was appropriate, up to the expected standards and was associated with quality outcomes. Annual audits of accounts will be carried out by a reputable firm and results published publicly.

These Guidelines will be reviewed regularly, in line with both clinical and fiscal developments. As presented, they represent the distillation of international best practice adapted for local solutions.

1 INTRODUCTION

The NHAct No. 8 of 2014 was enacted to ensure improved health outcomes, to provide a legal framework for the provision of health care services and to establish an organisational and management structure for the health system in Nigeria. To achieve this important objective of providing quality healthcare services to all Nigerians, the Act specifies that all Nigerians shall be entitled to a Basic Minimum Package of Health Services (BMPHS). The “Basic Minimum Package" is a set of preventive, protective, promotive, curative and rehabilitative health services or interventions, published from time to time by the Minister of Health, after consultation with the National Council on Health (NCH).

The Basic Health Care Provision Fund (BHCPF or “The Health Care Fund”) was established under Section 11 of the National Health Act, as the principal funding vehicle for the BMPHS, whilst at the same time, serving to increase the fiscal space and overall financing to the health sector. It is expected that the attendant service upscale arising from application of this funding, would assist Nigeria achieve Universal Health Coverage (UHC). Funding of this BHCPF would be derived, as stipulated in the Act, from contributions including (a) an annual grant from the Federal Government of Nigeria of not less than one per cent (1%) of its Consolidated Revenue Fund (CRF); (b) grants by international donor partners; (c) funds from any other source.

The NHAct sets out the important drivers to guide disbursement of the BHCPF. These **“Payment Gateways”** are three-fold:

- **i.** Fifty (50%) per cent (one half) of the Fund shall be disbursed through the National Health Insurance Scheme (NHIS) and deployed towards the provision of the Basic Minimum Package of Health Services (BMPHS) in eligible primary or secondary health care facilities;
- **ii.** Forty five (45%) per cent of the Fund shall be disbursed through the National Primary Health Care Development Agency (NPHCDA) and deployed to strengthening Primary Healthcare Centres (PHCs) in eligible primary healthcare facilities (essential drugs, vaccines and consumables; provision and maintenance of facilities, equipment and transport; development of human resources); and
- **iii.** Five (5%) per cent of the Fund shall be disbursed through a Committee appointed by the NCH and deployed towards emergency medical treatment.

Primary Health Care (PHC) is the foundational basis for the provision of healthcare services in Nigeria and this fundamental role is recognised by the Act in a series of Sections (3 and 11), designed to strengthen PHC. The current administration has also, in setting out its healthcare agenda, centred it around the provision of functional primary healthcare services in all political wards of the federation, with the ultimate objective of ensuring Universal Health Coverage (UHC) for all Nigerians. The BHCPF is key to achieving this agenda as well as increasing the fiscal space for health in Nigeria.

1.1 Rationale for selected interventions in Basic Minimum Package of Health Services

The Basic Minimum Package of Health Services (BMPHS) for Nigeria (2016) shall consist of nine (9) interventions; Urinalysis screening test and a Cardiovascular Disease (blood pressure, BP check) and treatment of malaria for all Nigerians, four (4) for Maternal Health interventions for pregnant women (ANC, labour and delivery care, EmONC, and caesarean section), two (2) for children (curative care and immunization).

A Basic Minimum Package of Health Services (BMPHS) is typically deployed to meet the elementary health needs of the entire population in countries where resources are limited. By aggregating services together, the BMPHS minimises costs, both of the services as well as the cost for patients to receive the services.

Health spending rarely matches demand and overall disease burden. This means that the demand for health services does not equal the supply of health services. As resources are always finite, there is no country that can provide health services to meet all the possible needs of its population therefore countries have to select which services to provide.

In 2016 the Fund will amount to about ₦225 per person per year. The current economic climate in Nigeria is challenging. To continue to fund healthcare services adequately going forward, the Government will have to consider innovative options. Tough choices have to be made including a review of the current system of annual allocations to public facilities, a reorientation in disease burden priorities, efficiency savings to reduce costs and increased private sector participation, especially in the delivery of care. All of these factors were taken into consideration as part of the process of defining a minimum package of services.

Determinations of actual interventions for the BMHPS content were informed by inclusion criteria such as: (a) most prevalent disease burden (b) cost-effectiveness and/or (c) equity. The World Bank has designated health interventions that cost less than US$100 per year of life saved as highly cost-effective for low and middle-income countries[1].

Difficulties faced by women in association with childbirth remain a significant cause for concern, brought into sharp focus by the very high Maternal Mortality Ratio (MMR) in Nigeria estimated at 576 per 100,000 births.[2] More than seventy percent (70%) of maternal deaths can be attributed to five major complications: (a) haemorrhage, (b) infection, (c) unsafe abortion, (d) hypertensive disease of pregnancy and (e) obstructed labour[34]. Given the huge impact of maternal morbidity and mortality on the disease burden in Nigeria, cost-effective interventions/services, which are likely to reduce the MMR have been prioritised in the Basic Minimum Package of Health Services.

Road Traffic Injuries (RTIs) are emerging as the leading public health concern in sub-Saharan Africa, against a backdrop of population health transitioning away from infectious diseases in children to non-communicable disease and injuries in adults. Nigeria has the highest road injury death rate (52.4 per 100,000 people) of any country globally[5]. The pedestrian death rate in West Africa at 13.4 per 100,000 and motorcyclist death rate at 17.5 per 100,000 are the highest in the world. In 2010, Nigeria had over 75,000 Road Traffic Injury fatalities, approximately thirty (30%) percent the total for sub-Saharan Africa[6]. Road Traffic Injury deaths in Nigeria ranked ahead of neonatal sepsis, preterm birth complications, protein-energy malnutrition, neonatal encephalopathy and meningitis, which are the most important causes of infant mortality. Similarly, Road Traffic Injury deaths in Nigeria killed more than three times as many people as Maternal Disorders and almost twice as many people as Tuberculosis. Road Traffic Injuries are now the fifth leading cause of death in Nigeria, up from eleventh in 1990[7]. The additional justification for reducing deaths from RTIs is the Sustainable

[1] Adeyi O, Smith O, Roble S. Public Policy and the Challenge of Chronic Non-communicable Diseases. World Bank 2007

[2] Nigeria Demographic and Health Survey 2013. National Population Commission Abuja, Nigeria 2014

[3] Khan KS, Wojdyla D, Say L, Gülmezoglu AM, Van Look PF. WHO analysis of causes of maternal death: A systematic review. Lancet 2006; 367:1066‑74.

[4] Omo‑Aghoja LO, Aisien OA, Akuse J.T, Bergstrom FE. Maternal mortality and emergency obstetric care in Benin City, South‑south Nigeria. J Clin Med Res 2010; 2:55‑60.

[5] Bhalla, K, Harrison, J, Shahraz, S, Abraham, JP, Bartels, D, Yeh, PH, Naghavi, M, Lozano, R, Vos, T, Phillips, D, Chou, D, Bollinger, I, Gonzalez-Medina, D, Wurtz, B, and Murray, CJL, 2013, Burden of Road Injuries in Sub-Saharan Africa, Department of Global Health and Population, Harvard School of Public Health, Boston, MA, africa.globalburdenofinjuries.org

[6] World Health Organization, 2013, Global status report on road safety - supporting a decade of action, World Health Organization: Geneva

[7] Bloom, D, Cafiero, ET, Jane-Llopis, E, Abrahams-Gessel, S, Bloom, L, Fathima, S et al., 2011. The Global Economic Burden of Non-Communicable Diseases. Geneva: World Economic Forum

Development Goal (SDG) 3.6[8]: "*Halve the burden due to global road traffic crashes by halving the number of fatalities and serious injuries by 2030 compared to 2010".*

As specified in Section 3 (3) of the National Health Act 2014, all Nigerians shall be entitled to a Basic Minimum Package of Health Services. To ensure that at least some, if not all interventions specified in the BMPHS are available to all Nigerians irrespective of age, religion, circumstances, domicile or health status, interventions directed against Hypertension (High Blood Pressure, HBP) which is the most common cardiovascular condition in Nigeria [prevalence rate between twenty two and twenty nine percent (22%-28.9%)][9][10] a urinalysis test for Diabetes[11] and treatment of malaria are included.

Whilst other services may become available in due course as a result of other initiatives, vertical programmes, private or community effort, these should be designed and implemented to complement and not act as substitute for the interventions contained in this BMPHS.

1.2 Purpose of the Guidelines

These Guidelines have been drawn up with explicit reference to the National Health Act, directives from the Minister of Health and following wide-ranging consultations with all relevant stakeholders in the Nigerian healthcare sector. They define the requirements for Administration, Disbursement, Monitoring and Financial Management (ADMFM) of the Fund. All stakeholders including (but not limited to) participating healthcare providers, healthcare facilities, Federal Government parastatals [National Health Insurance Scheme (NHIS), National Primary Care Development Agency (NPHCDA), Federal Road Safety Commission (FRSC), National Emergency Management Agency (NEMA)]; State Governments, Local Governments and their participating agencies including the State Primary Health Care Development Agencies (SPHCDAs) and States Supported Health Insurance Schemes (SSHIS); are expected to adopt, implement and comply with the stipulations set out in these Guidelines.

The overriding strategic objective of these Guidelines is to ensure that utilisation of the Fund catalyses improved health outcomes. This will be achieved through explicit targeting of specific areas of concern including maternal health and non-communicable diseases. During the development of the Guidelines, great emphasis was been placed on the ease and speed of implementation, safeguarding equity in health service delivery across Nigeria as well as entrenching a robust accountability and probity framework, which guarantees the prudent financial management of public funds.

Specifically, the primary purpose of these Guidelines is to:

- **i.** Set out the criteria for administration, disbursement, monitoring and financial management of the Basic Health Care Provision Fund as provided under Section 11 of the National Health Act;
- **ii.** Specify the eligibility requirements, terms of participation and attendant responsibilities for parties to access the Fund;
- **iii.** Stipulate the procedure for financial management of surplus funds at the end of each financial year;
- **iv.** Set out the requirements to be met by beneficiary health facilities;
- **v.** Enumerate the course of action for all other matters, which would ensure that the Basic Health Care Provision Fund achieves its intended objectives, as stated in the National Health Act.

[8] Sustainable Development Goals. New York, United Nations 2015

[9] Ekwunife OI, Nze Aguwa C. A meta-analysis of prevalence rate of hypertension in Nigerian populations. Journal of Public Health and Epidemiology 2011; 3 (13): 604-7

[10] Adeloye D, Basquill C, Aderemi AV, Thompson JY, Obi FA. An estimate of the prevalence of hypertension in Nigeria: a systematic review and meta-analysis. J Hypertens. 2015; 33(2):230-42

[11]

1.3 Establishment of the Fund

1.3.1 The Fund

The Basic Healthcare Provision Fund (BHCPF or "The Health Care Fund") is established by the National Health Act, No 8 of 2014.

1.3.2 Contributions into the Fund

Expected contributions into the Fund shall be as follows:

- **i.** Annual grant from the Federal Government of Nigeria amounting to not less than one percent (1%) of its Consolidated Revenue Fund;
- **ii.** Additional contributions from donors, international partners and others who wish to either donate or contribute into the Fund;
- **iii.** Funds from any other sources, including (but not limited to) investments and earned interest.

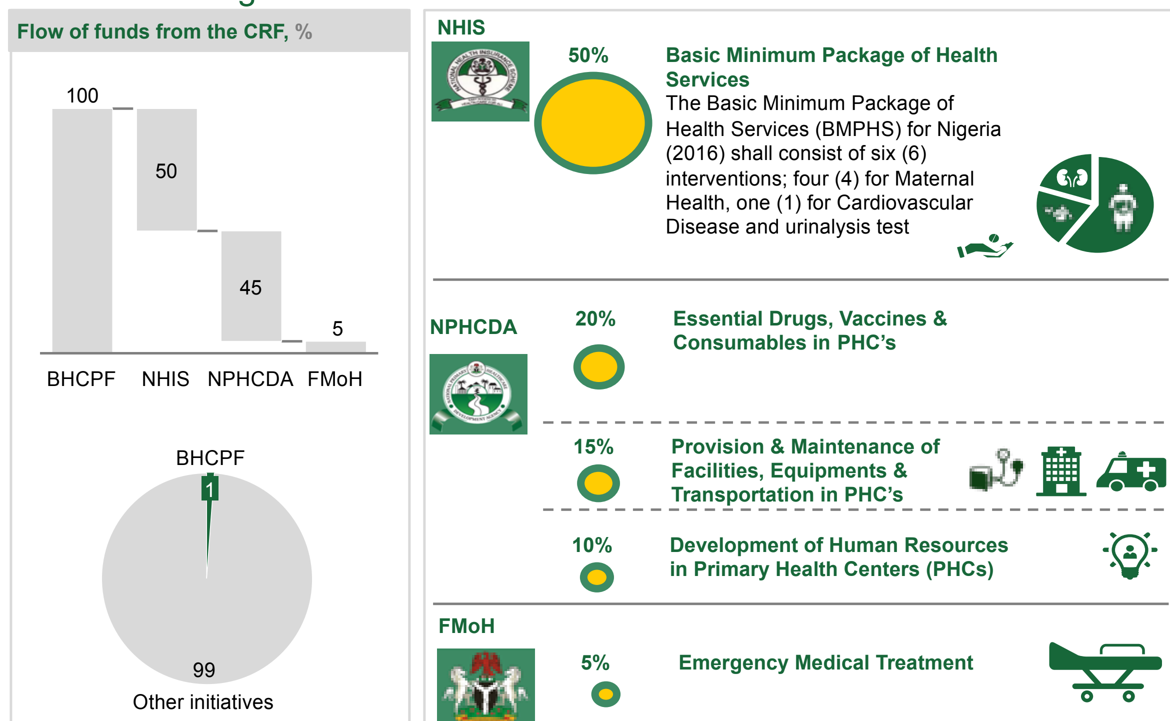

Figure 1: Sources of revenue inflows and disbursement stipulations of the BHCPF

1.3.3 Disbursement of the Fund

The Fund shall be disbursed in the following manner as provided by the National Health Act:

- **i.** 50 per cent of the Fund shall be used for the provision of basic minimum package of health services to citizens, in eligible primary or secondary health care facilities through the National Health Insurance Scheme (NHIS);
- **ii.** 20 per cent of the Fund shall be used to provide essential drugs, vaccines and consumables for eligible primary healthcare facilities;
- **iii.** 15 per cent of the Fund shall be used for the provision and maintenance of facilities, equipment and transport for eligible primary healthcare facilities;
- **iv.** 10 per cent of the Fund shall be used for the development of human resources for primary health care;
- **v.** 5 per cent of the Fund shall be used for emergency medical treatment to be administered by a Committee appointed by the National Council on Health.

2 GOVERNANCE OF THE FUND

2.1. National Council on Health (NCH)

i. The National Council on Health (NCH), as established by National Health Act 2014 (Sections 4 & 5), is the highest policy making body in Nigeria on matters relating to health.
ii. It shall ratify this initial version of the Guidelines for Administration, Disbursement, Monitoring and Financial Management of the Fund and any subsequent versions, as may be reviewed from time to time.
iii. The NCH shall approve and confirm the appointments of the Chairperson and Secretary of The Management Secretariat of The Health Care Fund (TMSOF).

2.2. Honourable Minister of Health (HMH)

i. The National Health Act 2014 (Section 11.7) confers on the Minister of Health, the authority to approve these Guidelines. The Minister of Health may also amend these guidelines and present same for ratification at the subsequent NCH meeting.
ii. The Minister shall establish the Management Secretariat of The health Fund (TMSOF) as the central coordinating body for the Administration, Disbursement, Monitoring and Financial Management of the Fund.
iii. The Minister shall set out the Terms of Reference of the TMSOF, appoint its members, facilitate its role and provide general oversight.

2.3. The Management Secretariat of The Health Care Fund (TMSOF)

This TMSOF is charged with the responsibility for stewardship and administration of the Fund, to be appointed by the Minister of Health. The Minister of Health shall appoint the Chairperson and Secretary of the Management Secretariat (TMSOF). The National Council on Health (NCH) shall confirm such appointments and tenure or duration. In addition, based on recommendations from the management of the NHIS and the NPHCDA, the Minister shall appoint two (2) representatives each of the NHIS and NPHCDA respectively, as members of the TMSOF. The Minister shall also appoint two (2) representatives of the FMoH to perform assigned roles for the FMoH. In order to facilitate successful implementation, the Secretary of the TMSOF and other members of the team will receive a Performance Bonus linked inter alia to timely and efficient disbursement of financing from the Fund.

2.3.1. Functions

The TMSOF is to:

i. Ensure adequate stewardship, regulation, governance and oversight of the Fund
ii. Have ultimate responsibility to ensure compliance of all agencies and bodies with these Guidelines.
iii. Procure, appoint and manage the Independent Verification Agents (IVAs).
iv. Procure, appoint and manage the external auditors.
v. Approve, together with the relevant agencies, payments to the recipients (SFAs, SPHCDAs, SSHIS's, TPAs) of the different gateways.
vi. Review regulations and requirements established by NPHCDA and the NHIS; Review, standardise and approve the service level agreements (i) between SPHCDAs/SFAs and the

relevant public facilities under the NPHCDA gateway; and (ii) between SSHIS/TPAs and private or public providers under the NHIS gateway.

vii. Serve as the Secretariat for Fund activities.

viii. Ensure that monies are disbursed, managed, and accounted for in a transparent and accountable manner, and in accordance with these Guidelines.

ix. Monitor the implementation of the Fund.

x. Establish and manage a system of complaints and redress for patients, communities, and providers.

2.3.2. Composition of The Management Secretariat of The Health Care Fund

The secretariat shall be composed of the following persons:

i. The Chairperson of the secretariat who shall be part-time and of proven integrity, and who shall function as the representative of the Minister of Health;

ii. The Secretary who shall be a person from either the Private or Public healthcare sector with not less than ten years' experience of healthcare financing, shall be the full-time Chief Executive, Accounting Officer, manage The Health Care Fund and work to implement these Guidelines, such person shall be appointed by the Minister of Health;

iii. Two representatives of the National Health Insurance Scheme (NHIS), one of which shall be the signatory on all matters pertaining to the role of the NHIS and the Fund;

iv. Two representatives of the National Primary Health Care Development Agency (NPHCDA), one of which shall be the signatory on the TMSOF for all matters pertaining to the role of the NPHCDA and the Fund;

v. Two representatives of the Federal Ministry of Health (FMoH), one of which shall be the signatory on the TMSOF for all matters pertaining to the role of the FMoH and the Fund;

vi. A Representative of Civil Society Organisations (CSOs) who shall act as an independent member of the TMSOF with particular responsibility for governance, accountability and prudence;

vii. A representative of the Labour union who shall act as an independent member of the TMSOF with particular responsibility for governance, accountability and prudence;

viii. A representative of private sector health care providers who shall act as an independent member of the TMSOF with particular responsibility for ensuring timely payment to providers and keeping the reporting burden reasonable; and

ix. Six representatives from the states, representing one (1) per geopolitical zone

x. A health economist of proven experience who shall guide program implementation.

Signatories to the Fund's CBN Accounts shall be as follows:

NHIS Gateway Transactions	Secretary + NHIS Representative
NPHCDA Gateway Transactions	Secretary + NPHCDA Representative
EMT Gateway Transactions	Secretary + EMTC Representative
Administration & Expenses Transactions	Secretary

2.3.3. Tenure

i. Each member of the TMSOF, with the exception of the Secretary, shall hold office for a term of four (4) years and no more; on such terms and conditions as may be specified in the letter of appointment;
ii. Each member of the TMSOF, with the exception of the Secretary may vacate office if a duly signed letter of resignation is sent to the Chairperson.
iii. The Secretary shall hold office for a period of four (4) years in the first instance and may be reappointed for a further term of four (4) years only; on such terms and conditions as may be specified in the letter of appointment.
iv. A member of the TMSOF may be removed from office by the Minister, subject to approval and ratification by the NCH, if the Minster is satisfied that it is not in the interest of the TMSOF or the public that the member should continue in office.

2.3.4. Domicile of the Management Secretariat

i. The Management Secretariat (TMSOF) shall be provided a suitable office accommodation within or outside the Federal Ministry of Health and would also report directly to the Minister of Health.

2.3.5. Liaison and Relationship between TMSOF, NHIS and NPHCDA

i. The TMSOF shall work in conjunction with the NHIS and the NPHCDA to realise stated outcomes pertaining to the Fund.
ii. As provided for under these Guidelines, the TMSOF shall ensure that obligations imposed on the NHIS and the NPHCDA are achieved in a manner, which is compatible with those set out in these Guidelines.
iii. The representative of the NHIS and the representative of the NPHCDA on the TMSOF shall approve and "sign-off" on all aspects of disbursement of the Fund, related to their respective organisations, in accordance with stipulations of the National Health Act 2014.
iv. Decisions and determinations of the TMSOF on the Fund shall be binding on, and deemed as those taken by, the FMoH, NHIS and the NPHCDA.

2.3.6. Liaison and Relationship between TMSOF, SPHCDAs and SFAs

i. The TMSOF shall work closely in conjunction with SPHCDAs, through the State Fund Administrator (SFA) in each State, to realise the stated objectives of the Fund.
ii. As provided for under these Guidelines, the TMSOF has oversight and a supervisory role over the SPHCDAs, through the SFA, to ensure compliance with these Guidelines, which is required in order to guarantee continuous flow of direct transfers to healthcare facilities.

2.3.7. Compliance and Sanction powers available to the TMSOF

The TMSOF acting with the consent and on behalf of the Minister of Health, FMoH, NHIS and NPHCDA, from which it derives its authority and legitimacy, shall ensure full implementation and compliance with the Guidelines including through:

i. Issuing written advisory and reminders to non-complying States, Local Governments and/or healthcare facilities.
ii. Deferring payments to non-complying States, Local Governments and/or healthcare facilities until such requirements or advisory in Guidelines and other necessities are met.
iii. Suspending payments to non-complying States, Local Governments and/or healthcare facilities.

3 ADMINISTRATION OF THE FUND

This section of the Guidelines sets out how the Fund will be administered as well as the key functions of public-sector entities as it pertains to the Fund.

The National Health Act 2014 confers specific responsibilities on a number of public-sector agencies to fulfil certain functions in the administration of the Fund. These Guidelines stipulate the roles and duties of these key public-sector bodies, other organisations and stakeholders in the implementation of the Fund.

3.1 Key Stakeholders

3.1.1 Central Bank of Nigeria (CBN)

- **i.** The BHCPF shall be domiciled in a designated account operated and maintained at the Central Bank of Nigeria.
- **ii.** All contributions into the Fund shall be paid into this account at the CBN.
- **iii.** Disbursements from the Fund shall be made from the designated account as direct credits into bank accounts of recipients.
- **iv.** The four (4) signatories (CEO/Secretary, NHIS Representative, NPHCDA Representative and FMOH Representative) to operate this account, shall be members of the Management Secretariat.
- **v.** The Banking Mandate submitted to the CBN, governing the operation, disbursement and monitoring of the account, shall be developed by the TMSOF and approved by the Minister of Health.

3.1.2 National Health Insurance Scheme (NHIS)

- **i.** The National Health Insurance Scheme (NHIS) shall provide the Basic Minimum Package of Health Services (BMPHS) to all Nigerians, in eligible primary or secondary health care facilities.
- **ii.** The provision of the BMPHS shall be through the process of Strategic Purchasing, funded through the **"NHIS Gateway" (50 percent of the BHCPF),**
- **iii.** The State Health Insurance Schemes and or Third Party Administrators (TPAs) shall, on behalf of the NHIS, accredit and empanel primary and secondary health care facilities using simple, inclusive criteria[12] to participate in this initiative to provide healthcare services. These criteria are contained in Appendix. The NHIS may also wish to leverage on existing state owned institutions, which have mandates for facility accreditation for this purpose.
- **iv.** NHIS will be responsible for: (i) the recruitment, appointment, and management of the SSHIS's or TPAs; (ii) provide technical support to the SSHIS's and TPAs; (iii) establish the regulations covering accreditation and quality of care (although these will be subject to review by the TMSOF); (iv) be responsible for timely payments to the TPAs and SHIS's; and other functions that the Minister of Health may reasonably give them based on implementation experience;
- **v.** The combined Administrative Costs to NHIS, NHIS for carrying out these roles and functions has been capped at and shall not exceed half a (0.5%) percent of the BHCPF.

12 Criteria for accreditation of Primary and Secondary Healthcare Facilities into the initiative have been developed and are outlined in the Appendix. The criteria include minimum requirements on staffing, equipment, premises and support

3.1.3 National Primary Health Care Development Agency (NPHCDA)

i. The National Primary Care Development Agency (NPHCDA) and all State Primary Health Care Development Agencies (SPHCDAs) shall, through the process of Decentralised Financing for Accountability and Results (DFAAR)), strengthen the operations of Primary Healthcare Centres (PHCs) across Nigeria.
ii. NPHCDA shall strengthen the operations of PHCs through the **"NPHCDA Gateway," (45 percent of the BHCPF).**
iii. The NPHCDA gateway shall provide funding to eligible Primary Health Care facilities for specific areas of healthcare including: (i) provision of essential drugs, vaccines and consumables; (ii) provision and maintenance of facilities, equipment and transport; (iii) development of human resources.
iv. The National Primary Health Care Development Agency shall develop regulations and standards for PHC facilities (although these will be subject to review by the TMSOF).
v. NPHCDA will provide technical support to the SPHCDAs and review the performance of the PHC systems in the states based on various sources of data.
vi. NPHCDA will be responsible for the timely payment of the SFAs/SPHCDAs after approval is sought from the TMSOF.
vii. The combined Administrative Costs, made up of payments to NPHCDA and State Primary Health Care Development Agencies (SPHCDAs) for carrying out these roles and functions has been capped at and shall not exceed two and a quarter (2.25%) percent of the BHCPF.

3.1.4 Emergency Medical Treatment Committee (EMTC)

i. The role of the Emergency Medical Treatment Committee (EMTC) will be undertaken by the TMSOF. It shall ensure the provision of basic Emergency Medical Treatment (EMT) for all Nigerians, by eligible Ambulance Services and designated Emergency Care facilities
ii. The provision of EMT shall be through the process of Strategic Purchasing, funded through the "**EMT Gateway" (5 percent of the BHCPF**)
iii. The day-to-day implementation of the EMT gateway, including any commissioning that is required, shall be carried out by Federal Ministry of Health (FMOH) staff designated by the Minister of Health on the TMSOF.
iv. The combined Administrative Costs, consisting of payments to TMSOF for carrying out its roles and functions in overseeing the strategic framework of the EMTC, has been capped at and shall not exceed one quarter of one (0.25%) percent of the BHCPF.
v. To ensure adequate disbursement, administration and monitoring of the EMT Gateway and the five percent (5%) section of the Fund, the functions of the Emergency Medical Treatment Committee (EMTC) shall be subsumed under the TMSOF.
vi. The TMSOF will carry out the functions of the Emergency Medical Treatment Committee (EMTC) and shall supervise the administration and disbursement of the five (5%) per cent proportion of the Fund, set aside for Emergency Medical Treatment

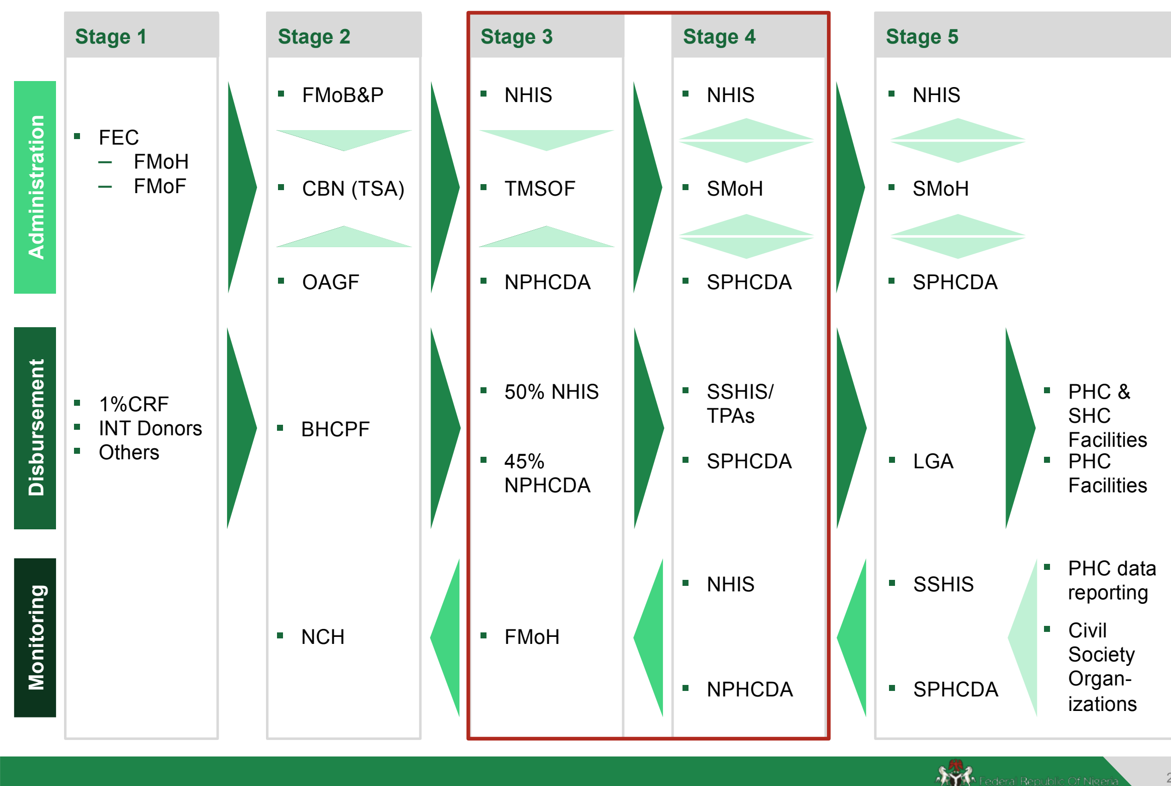

Figure 2: Overview of key Stakeholders, Administration, Disbursement and Monitoring of the BHCPF

3.1.5 State Primary Health Care Development Agencies (SPHCDAs)

i. State Primary Health Care Development Agencies (SPHCDAs) shall provide an additional layer of capacity and oversight for implementation of the payment process of Decentralised Financing for Accountability and Results (DFAAR), funded through the NPHCDA Gateway (45 percent of the BHCPF).

ii. All funds received on this account by the SPHCDAs shall be transferred electronically to PHC facilities within a period of not more than two (2weeks) after the funds have been received.

iii. Funds transfer by the SPHCDA to providers will be carried out on a monthly or quarterly basis, to enable the PHCs address service delivery.

iv. It shall be a pre-condition for accreditation of primary healthcare facilities in all States, who wish to benefit from this operational funding for specific areas of PHC, that their State Government has established (or is in the process of establishing) a State Primary Health Care Development Agency (SPHCDA).

v. The combined Administrative Charge of all SPHCDAs and the NPHCDA for carrying out these functions and roles shall be capped at and shall not exceed two and a half (2.5%) percent of the BHCPF.

vi. The SPHCDAs shall receive at least eighty five (85) per cent (in equal sums) of the capped Administrative Charge for carrying out their functions under these Guidelines.

vii. Both the NPHCDA and SPHCDAs shall have oversight roles over accredited primary healthcare facilities.

viii. The NPHCDA and SPHCDA shall be entitled to receive five (5) copies each of the quarterly statutory progress reports and annual statement of accounts, on the utilisation of financing provided by the Fund.

3.1.6 State Supported Health Insurance Scheme/ Third Party Agents/Administrators (TPAs)

I. States shall set up their SSHIS in line with the guidelines from the NHIS.
II. States without SSHIS may contract TPAs to provide this function in the first instance.
III. The functions and roles assigned to contracted SSHIS or TPAs would include: (i) Accreditation of Healthcare Providers (ii) Provider Management, including Case Management (iii) Fund Management (iv) Call-Centre Operations (v) Service Level Agreements governing such processes (vi) Liaison between TMSOF, NHIS, SPHCDA and SFA (Regulator Relations) (vii) any other function outsourced to the SSHIS/TPA.
IV. The SFA/SSHIS acting for and on behalf of the NHIS and SPHCDA may procure, appoint and manage TPAs who shall be engaged provisionally for three (3) years in the first instance.
V. At the expiration of the initial three (3) year contract, the contract may be renewed provided there is a favourable assessment of performance of the TPA on designated functions and review of the number of complaints made against the TPA.

3.1.7 State Ministries of Health (SMoH) and the FCT

i. The State Ministries of Health (SMoH) shall provide leadership at State level to ensure successful implementation of the initiative in each State.
ii. The Commissioner of Health (in each State and FCT) shall appoint a **"State Fund Administrator" (SFA)** who shall:
    (i) Be domiciled in the SPHCDA;
    (ii) Lead and ensure implementation of these Guidelines;
    (iii) Monitor, track and prepares reports on disbursement of the Fund at State level.
    (iv) Facilitate the independent verification process;
    (v) Receive and forward to the TMSOF, all Annual Reports and Returns submitted;
    (vi) Provide a certified list of all PHCs supported by the Fund in the state to the TMSOF.
iii. The SFA shall hold office for a period of four (4) years in the first instance and may be reappointed for a further term of four (4) years only on such terms and conditions as may be specified in the letter of appointment.
iv. A SFA may be removed from office by the Commissioner of Health, if the Commissioner is satisfied that it is not in the interest of the SPHCDA or the public that the SFA should continue in office.
v. For a period of at least five (5) years starting immediately after the date of approval of these Guidelines, each State shall make annual budgetary provisions for operational expenses in Primary Healthcare Centres (PHC).
vi. Such budgetary provision shall be reflected in the annual SPHCDA budget as PHC overhead costs. As much as practicable, the appropriation shall be disaggregated in line with provisions of the National Health Act whereby 20 per cent is earmarked for essential drugs, 15 per cent for maintenance of facilities and 10 per cent for human resources development.
vii. Signatories to the Fund's BHCPF SPHCDA Account shall be as follows:

NPHCDA/SPHCDA Transactions	SFA + SPHCDA Representative(s)
Administration & Expenses Transactions	SFA

3.1.8 Local Government Administration

i. The Local Government Administration (LGAd) shall provide leadership at Local Government level to ensure successful implementation of the initiative in each Local Government Area (LGA).

ii. Given the push for PHC under one roof (PHCUOR), and the role of SPHCDAs as guardians of primary health care delivery, the budgetary provisions for operational expenses made by the SPHCDA will suffice as State's conditions for accessing the grant.

3.1.9 Primary Healthcare Centres (PHCs)

i. Primary Healthcare Centres (PHCs) shall be the first point of contact for patients who are seeking and receiving care from accredited providers under this initiative.

ii. PHCs shall provide all of the essential preventive, curative and rehabilitative healthcare services offered in the BHPMS and serve as gatekeepers for the initiative.

iii. PHC facilities, which meet the accreditation criteria set out by the NHIS/SSHI's/TPAs shall receive funding through both Provider Payment Mechanisms (PPMs): (i) the NHIS (50%) Gateway as **"Global Payments (GP)"** disbursed from the Fund through SSHIS's TPAs and (ii) the NPHCDA (45%) Gateway as **"Decentralised Financing for Accountability and Results (DFAAR)"** disbursed from the Fund through SPHCDAs.

iv. The PHCs shall have patent bank accounts with signatories including the OIC and a member of the WDC

v. Under the NPHCDA Gateway, PHC facilities shall receive on a quarterly basis, and in advance direct electronic transfer from the SFAs.

vi. Funds received by the PHCs shall be used in strengthening health service delivery. Facilities are encouraged to use funds for improving commodity availability and community outreaches

vii. Participating PHC facilities shall be required to produce and submit Income and Expenditure Statements for monies received from the Fund, to the SFA at the end of each financial year.

3.1.10 Secondary Health Care (SHC) Facilities

i. Secondary Health Care (SHC) facilities shall provide specialist services to patients seeking and receiving such care from accredited specialist providers in this initiative.

ii. In this initiative, patients can only access SHC specialists through a written referral from their PHC provider.

iii. Both public and private sector SHC facilities can be involved in the initiative therefore, eligible for accreditation without any discrimination.

iv. SHC facilities, which meet the accreditation criteria set out by the NHIS/SSHIS's/TPAs shall receive funding through the relevant Provider Payment Mechanism (PPM) which is the NHIS (50%) Gateway as "Global Payments (GP)" disbursed directly from the Fund.

v. SHC facilities shall be paid retrospectively upon confirmation of service provided.

vi. Participating SHC facilities shall be required to produce and submit Income and Expenditure Statements, for monies received from the TMSOF, at the end of each financial year.

3.1.11 Civil Society Organisations (CSOs)

Civil Society Organisations (CSOs) with a proven history of involvement in health sector monitoring and development shall provide independent oversight for the Fund. Such functions shall be carried out through:

i. The monitoring of disbursements by the TMSOF and ensuring robust financial management.

ii. Annual independent audits and assessment reports.

3.2. Key Processes

3.2.1. Memorandum of Understanding (MoU)

i. Each participating State Government (and the FCT), through its SPHCDA shall sign a Memorandum of Understanding (MoU) with the TMSOF to govern its participation in the initiative.

ii. This MoU shall set out details of involvement, expected benefits as well as obligations of the State, including estimated amounts allocated for disbursement, reporting obligations, service-level agreements (SLAs) and reporting requirements, especially of health metrics and indicators.

iii. The MoU shall include an agreement that funds may be routed through SPHCDAs but such funds are for immediate disbursement to accredited and eligible health facilities.

3.2.2. Counterpart Funding

i. Under the National Health Act 2014, States (and the FCT) and Local Governments shall provide counterpart funding of twenty five percent (25%) each of the sum being disbursed to obtain financing from the Fund.

ii. Use of counterpart funding as a mechanism to engender State participation, inclusion and ownership of federally led programs have in the past not yielded the desired results. The Universal Basic Education Fund readily comes to mind. The fund, which now has in excess of N58bn, continues to lie fallow with States unable to access it due to fiscal constraints. The Federal Government has recently called for a loosening of the conditions set in the UBEC act to increase States access to the fund.

iii. Recognising these challenges, innovative solutions that ease the conditions for disbursement and enable flow of funds to frontline service delivery points are required. In this regard, the conditions for accessing the funds arising from the NPHCDA gateway are as follows:

   a. Each State shall for a period of at least five (5) years starting immediately after the date of approval of these Guidelines, make annual budgetary provisions for operational expenses in Primary Healthcare Centres (PHC).
   b. This budgetary provision shall be reflected in the annual SPHCDA budget as PHC overhead costs. As much as practicable, the appropriation should be disaggregated in line with provisions of the National Health Act whereby 20 per cent is earmarked for essential drugs, 15 per cent for maintenance of facilities and 10 per cent for human resources development.
   c. Each SPHCDA shall receive 40% of the total possible sum per State in the first instance upon confirmation by the TMSOF that budget lines have been created for PHC operational expenses in the annually published budgets.
   d. A second tranche of disbursement of not more than 15% of the funds shall be made in the following quarter as soon as the evidence of timely payment from the SPHCDAs to the PHCs has been verified.
   e. A third tranche of disbursement of not more than 15% of the funds shall be made in the following quarter as soon as the evidence of timely payment from the SPHCDAs to the PHCs has been verified.
   f. A final tranche of disbursement of 30% of the funds shall be made to the SPHCDAs upon release of their annual financial statements and audited accounts.
   g. States who are unable to produce their annual financial statements and audited accounts four (4) months into a new fiscal year will be deemed to have forgone the final tranche of payments.

iv. The TMSOF shall monitor the actual release of the funds provided in the Appropriated Budgets of State Governments, FCT or Local Governments.

v. State Governments and the FCT, at the beginning of each year or as soon as is practically possible, may send five (5) copies of their budget to the TMSOF with a request for release of any due payments from the Fund.

vi. **Sunset Clause:** After the initial period of five years, a fresh set of Guidelines shall be drawn up outlining the terms for the provision of counterpart funding by States, FCT and Local Governments

3.2.3. Annual Reports, Financial Accounts and Filings

i. Each participating State through its SPHCDA and SSHIS shall be required to submit to the TMSOF, at the latest by 30th of April of the following year, annual Audited Accounts (including Bank Statements and Payment Vouchers) on all disbursements received by the State from The Fund, in the preceding financial year (January to December).

ii. The TMSOF shall receive, collate and publish all these Audited Accounts with an overview of the current status of The Fund, in an Annual Report on or before 30th June of the following year.

3.2.4. Administrative Expenses

i. The bulk of financing from the Fund shall be directed at meeting the costs of patient care.

ii. The TMSOF shall thus utilise and leverage on existing organisational structures and mechanisms at the Federal, State and Local Government levels for administration, disbursement and monitoring.

iii. All administration expenses, including disbursement, monitoring and data collection costs to be incurred by the TMSOF, SPHCDA and LGAD shall be paid for through the delineation of an annual allowance. This annual allowance shall not exceed an annual maximum limit of five percent (5%) of the funds accruing to The Fund. This sum shall be set aside for this purpose. The amount set as administrative expenses may increase subject to approval by the Minister.

3.2.5. Roll-Over of Excess Funds

i. At the end of each financial year, where an annual surplus arises in the Fund as a result of underutilisation, poor uptake or any other development and having settled all outstanding claims and cash-calls, any such surplus funds shall be rolled-over to be paid back into the next years' Fund.

ii. Liquidation of any financial assets of the Fund such as the Treasury Bills, for any purpose, shall require approval by the TMSOF (simple majority voting) and authorisation by the Minister of Health.

iii. States who do not meet the requirements for funds disbursement in any given year have no recourse to retrieving the funds retrospectively.

iv. At the beginning of each year, the total sum available shall be the sum of any rolled-over funds and the new accruals from the different revenue sources.

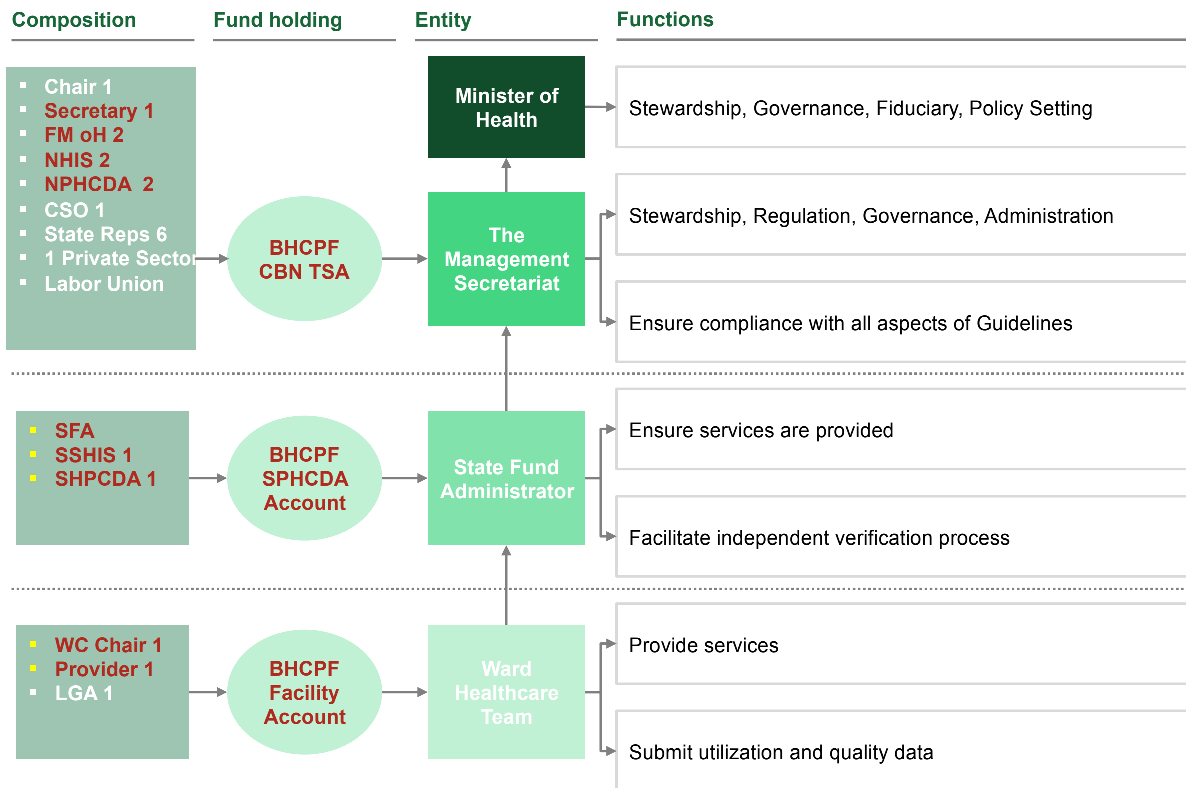

Figure 5: Governance Structure for Administration of the Fund

4. SERVICES AND SERVICE PROVISION

4.1. Provision of Healthcare Benefits

The details of interventions to be included in the Basic Minimum Package of Health Services (BMPHS), developed for this initiative are outlined below (Table 2):

- **i.** The Basic Minimum Package of Health Services (BMPHS) for Nigeria (2016) shall consist of nine (9) interventions; Urinalysis screening test and a Cardiovascular Disease (blood pressure, BP check) and treatment of malaria for all Nigerians, four (4) for Maternal Health interventions for pregnant women (ANC, Labour and Delivery, EmONC and caesarean section), two (2) for children (curative care and immunization). Every Nigerian will be entitled to accessing this level of care without charge at the point of care, which guarantees most interventions required for safe antenatal care and delivery, as well as regular blood pressure screening
- **ii.** A phased approach shall be implemented for the introduction of these interventions in the BMPHS to the population.
- **iii.** Except for Emergency Medical Treatment, in the first instance, during the first five years of operation of this initiative, the BMPHS will be available to only those who live in RURAL areas, with subsequent extension to other areas after the initial five year period.

Delivery methods and recommended interventions for the select clinical services

(1) Intervention 01 (2) Intervention 02 (3) Intervention 03

1. Maternal Health Services

Antenatal Care (ANC)	Labour & Delivery Care
Minimum of 4 ANC visits (1) Malaria prevention with Intermittent Preventive Treatment (IPT): Sulpha-doxine and Pyrimethamine; PMTCT (HIV/AIDS) (2) ITN, Folic Acid, Iron, Doctor must see at one of the first two visits visit (3) Ultrasound Scan (Max 3), Urinalysis, Haemoglobin, HIV, Hep B	**Skilled Birth Attendants (SBAs) at all facilities** (1) Partograph Monitoring (2) Episiotomy & Repair (3) Post-Natal care including mother and baby care, from first visit within 48 hours of delivery to second visit 6 weeks post-partum.
Emergency Obstetric and Neonatal Care (EmONC)	**Clinically-indicated Elective Caesarean Section, Instrument delivery (forceps delivery, vacuum extraction)**
Basic & Comprehensive Emergency Obstetric and Neonatal Care (1) IV/IM Antibiotics, IV/IM Oxytoxics, IV/IM Anti-convulsants, Manual removal of placenta, Assisted vaginal delivery, Removal of conception retained products; Essential Newborn care (2) All seven BEmONC functions plus Emergency Caesarean Section, Blood Transfusion	**Chorio-amnionitis, Gestational Diabetes, Hypertension, Multiple pregnancy, Placenta Praevia, Pre-eclampsia and Eclampsia, IUGR**

2. Prevention and Treatment of Non-Communicable Diseases (NCDS), Other services covered

Hypertension	Primary Care Blood Pressure Monitoring; Secondary Prevention Education Malaria Under five curative illnesses	(1) Lifestyle interventions for preventing Hypertension	(2) Advice on Blood pressure control in people with pressure higher than 140/90 mmHg

Table 2: Contents and Interventions in some Basic Minimum Package of Health Services (BMPHS) for Nigeria 2016 (excluding Emergency Medical Treatment)

The EMT component of the BMPHS shall consist of three (3) modules:

i. **Scene** ***(Emergency Pre-Hospital Care):*** Tier One First Responder, Tier Two Basic Prehospital Trauma Care, Tier Three Advanced Prehospital Trauma Care, Care Documentation
ii. **Transfer** ***(Transportation & Communication):*** Field Triage, Ground Transportation, Air Medical Transport, "Universal" Telephone Number
iii. **Facility** ***(Initial Evaluation, Diagnosis & Resuscitation and In-Hospital Care):*** Reception-Registration, Screening, Triage, Handover; Emergency Unit Care-Initial Assessment & Resuscitation, Monitoring and Revaluation, Detailed Assessment, Diagnostic Studies, Additional Therapeutics; Inpatient Care-Early Operative Care, Early Critical Care

4.2. Accreditation

One of the objectives of the BHCPF is to improve access and utilisation of basic maternal health services with a special emphasis on the poor who are more represented in rural areas. The use of Skilled Birth Attendants (SBA) is far lower in rural (23%) compared with urban (67%) areas and among the poorest income quintile (5.7%) compared with the highest income quintile (85.3%)[13]. Given the need to reach the rural and poor communities, these Guidelines sets out accreditation standards which are deemed appropriate for the intended (rural) healthcare providers; which may be less stringent initially, but will increase over time. This is a deliberate pro-poor benefit of the BPHCPF.

i. Any rural provider that wishes to participate in the initiative shall be accredited by relevant TPAs or SSHIS as an entry requirement.
ii. The accreditation process (see Appendix for sample Process Form) will be simple. It shall consist of data capture electronic (where possible) and be based on clinical functionality rather than just physical assets.
iii. The fifteen (15) basic requirements for Accreditation of **Rural Primary Healthcare Centres** are as follows:

[13] National Population Commission (NPC) [Nigeria] and ICF International. 2014. Nigeria Demographic and Health Survey 2013. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.

. . .

Requirement	Satisfied: Yes	Satisfied: No
1 Skilled Health Worker (doctor, nurse, midwife, or CHEW)	☐	☐
2 Sphygmomanometer	☐	☐
3 Foetoscope	☐	☐
4 Stethoscope	☐	☐
5 Delivery Bed	☐	☐
6 Battery-powered Torch or other light source	☐	☐
7 Partogram	☐	☐
8 Patient Records (weight, blood pressure, etc. where each antenatal care visit is documented)	☐	☐
9 Mobile Phone	☐	☐
10 Essential Drugs		
a. Magnesium sulphate	☐	☐
b. Oxytocin or Ergometrin or Misoprostol	☐	☐
11 Disposable or Reusable Gloves	☐	☐
12 Sterilisable Scissors	☐	☐
13 Sterilisable Cord Ties	☐	☐
14 Functioning Bank Account	☐	☐
15 Running water and soap or Hand sanitiser	☐	☐

Table 1: Basic Accreditation Requirements for Rural PHCs

4.3. Healthcare Provider Rights and Responsibilities

4.3.1. NHIS Providers

- **i.** Both public and private sector (rural) healthcare providers shall be eligible to apply for accreditation and participate in the initiative.
- **ii.** To be eligible and receive payment in this initiative, each healthcare provider has to be accredited by the SSHIS/ Third Party Agent, acting on behalf of the NHIS.
- **iii.** Each facility shall meet the minimum criteria of quality standards before it can be accredited. A quantitative quality supervisory checklist (developed by the NHIS) will be administered to all enrolled facilities to monitor and ensure a consistent level of quality.
- **iv.** Healthcare providers shall not refuse treatment to any patient under the initiative or charge user fees, either as a “Top-Up” or as “Co-Payment”
- **v.** The provider will be obliged to display a large sign in front of its building publicizing: (i) the fact that it provides free care for all mothers and will not charge on top of the fee provided through this gateway; (ii) will provide free blood pressure and diabetes screening; and (iii) providing the telephone number and web address of the redress mechanism established by the TMSOF.
- **vi.** Pre-selected public and private sector providers shall be paid a bundled fee to provide a defined package of services at no cost to the target population.
- **vii.** Healthcare providers shall maintain high standards of medical record keeping and submit both clinical and administrative data to the SSHIS/TPAs (for onward transmission to the TMSOF) as and when due. The providers will allow auditors and IVAs designated by the TMSOF access to their records;

viii. Healthcare providers shall develop and maintain a robust referral system for the management of emergency or complicated patients, so there is direct access between primary care provider and neighbouring secondary health facilities with the capacity to manage any such cases.

ix. Any patient determined to require emergency care, must be promptly referred and arrive at the secondary centre within **one (1) hour (60 minutes**) of the decision being made.

x. Selection and continued participation in the initiative is contingent on the healthcare provider continually improving its quality of care.

4.3.2. PHC Providers

i. Primary Health care facilities selected based initially on the One Functional PHC per Ward strategy shall be eligible to apply for accreditation and participate in the initiative.

ii. To be eligible and receive payment in this initiative, each healthcare provider shall be empanelled by the SFA/SPHCDA.

iii. In order to ensure a consistent level of quality, each facility shall meet the minimum criteria of quality standards before it is eligible to be empanelled.

iv. The SFA/SPHCDA shall ensure there is at least one (1) participating PHC facility in every Ward.

v. The SFA/SPHCDA shall ensure every participating PHC facility opens and operates a bank account.

vi. The SFA/SPHCDA shall ensure that the signatories to the account shall be the Officer-In-Charge of the PHC (Primary Provider) and the Ward Development Committee (WDC) Chairperson.

vii. The SFA/SPHCDA shall encourage active community participation in the PHC facility operations.

viii. The PHC and community, through the Ward Development Committee, shall have considerable autonomy over the utilisation of payments from the Fund; to be used as required for the improvement of facility-based services and for outreach.

ix. The PHCs will be expected to use the funds for demand generating activities, community outreaches, health promotion and prevention activities, basic repairs, procurement of basic commodities and vaccine retrieval from the cold chain store.

x. The PHC will not provide any payment to any State or LGA official.

xi. Where there is low demand for care, PHCs shall be required to focus on community outreach.

xii. Healthcare providers shall maintain high standards of medical record keeping and submit both clinical and administrative data to the SPHCDA/SFA (for onward transmission to the TMSOF) as and when due.

xiii. Selection and continued participation in the initiative is contingent on the healthcare provider maintaining adequate quality standards of care.

xiv. Healthcare providers must remain in good professional standing with their registration bodies, including meeting Continuous Professional Development (CPD) requirements.

xv. PHCs will be obliged to put up a large sign outside the premises indicating that the facility provides free maternal care, free hypertension and diabetes screening, and free immunization.

4.3.3. EMT Providers

i. Ambulance Service Providers shall provide, as a standard of care, “Scene Incident Managers (SIMs)” who shall secure the scene, coordinate the Emergency Response, all communications and transport at and from the RTI scene

ii. Both private-sector and public-sector healthcare providers shall be eligible to apply for accreditation and participate in the initiative

iii. To be eligible and receive payment in this initiative, each healthcare provider has to be accredited by the MFI acting on behalf of the EMTC
iv. Each facility shall meet the minimum criteria of quality standards before it can be accredited. A quantitative quality supervisory checklist will be administered to all enrolled facilities to monitor and ensure a consistent level of quality.
v. Healthcare Providers shall not refuse treatment to any patient under the initiative or charge user fees, either as a “Top-Up” or as “Co-Payment”
vi. Emergency Care Providers shall maintain high standards of medical record keeping and submit both clinical and administrative data (for onward transmission to the TMSOF) as and when due.
vii. Ambulance Service Providers shall develop and maintain a robust communications and referral system for the management of emergency patients, so there is direct access between Ambulance Service Provider and neighbouring Emergency Care facilities with the capacity to manage any such cases.
viii. Any patient determined to require emergency care, must be promptly transported and arrive at the Emergency Care centre within **half an hour (30 minutes**) of the decision being made.
ix. Selection and continued participation in the initiative is contingent on the healthcare provider maintaining adequate quality standards of care.
x. Healthcare Providers must remain in good professional standing with their registration bodies, including meeting Continuous Professional Development (CPD) requirements.

5. DISBURSEMENT AND ALLOCATION OF THE FUND

5.1. Guiding Principles

The disbursement of monies from the Fund is designed to be simple and transparent. To this end, an allocation formula where **all thirty-six (36) States and the FCT receive an equal share of the Fund** (irrespective of land mass, population, and disease burden) has been adopted. Through this funding mechanism, it is expected that the majority of states (and the FCT) would be in a position to access the funds on a regular basis. In recognition of this principle:

i. Each State shall make annual budgetary provisions for operational expenses in Primary Healthcare Centres (PHC) to satisfy the requirement for counterpart funding outlined in Section 11 (5) of the National Health Act 2014.

ii. Payments shall be disbursed from the BHCPF accounts to a dedicated SPHCDA account for immediate and onward transfer to facilities. Such dedicated account shall be setup to receive credits before disbursements commence.

iii. The disbursement cycle shall be on a monthly/quarterly basis subject to the beneficiaries providing adequate monitoring and quality information to the TMSOF.

iv. The Fund shall be utilised primarily for three purposes to:
   a. Pay for the provision of the Basic Minimum Package of Health Services (BMPHS) as defined in these Guidelines; and
   b. Fund the operational expenses of Primary Healthcare Centres (PHCs) across Nigeria
   c. Provide basic Emergency Medical Treatment, initially focused on Road Traffic Injuries (RTIs) arising from “accident hotspots “ across Nigeria

5.2. Fund Access

I. Access to the Fund for payments for care delivered would be open to all (public-sector and private-sector) providers, in all States (and FCT) of the Federation.

II. To improve access and quality of care in rural areas, **during the first five (5) years of operation of the NHIS Gateway, sole preference shall be given to healthcare providers situated in Rural Areas**[14]. Throughout this initial period, zero funding would be available for healthcare providers in urban areas. For the providers in rural areas as defined by the National Population Commission (NPopC), maximum assistance for accreditation would be provided so that at least “one healthcare facility per ward” is able to participate in this initiative.

5.3. Funding Gateways

I. The process pathways through which disbursement and claims shall be funded have been designed in line with the provisions of National Health Act 2014. The “NHIS Gateway”, is the pathway by which 50% of the BHCPF will be disbursed. The Provider Payment Mechanism for this process is termed “Global Payments.” The second pathway through which 45% of the Fund will be disbursed is known as the “NPHCDA Gateway” which will utilise the Provider Payment Mechanism known as “Decentralised Financing for Accountability and Results (DFAAR)”. The third is the “EMT Gateway”, which is the pathway by which 5% of the

[14] Definition of a Rural Area in Nigeria will be based on population size of the conurbation

BHCPF will be disbursed for Emergency Medical Treatment. The Provider Payment Mechanism for this process is also termed “Global Payments.”

II. In the **Global Payments Mechanism**, funds are disbursed using the traditional “fee-for-service” principle; the provider makes a claim for payment after the treatment has already been provided.

III. In the **DFAAR Payment Mechanism**, funds are disbursed subject to the fulfilment of conditions listed in section 2.1.16 (counter part funding) above

IV. In both instances, the financing mechanisms are output-based, and in line with international best practices.

V. Payments shall be made on a monthly or quarterly basis, subject to the SFA and TMSOF receiving meaningful monitoring and quality assurance data.

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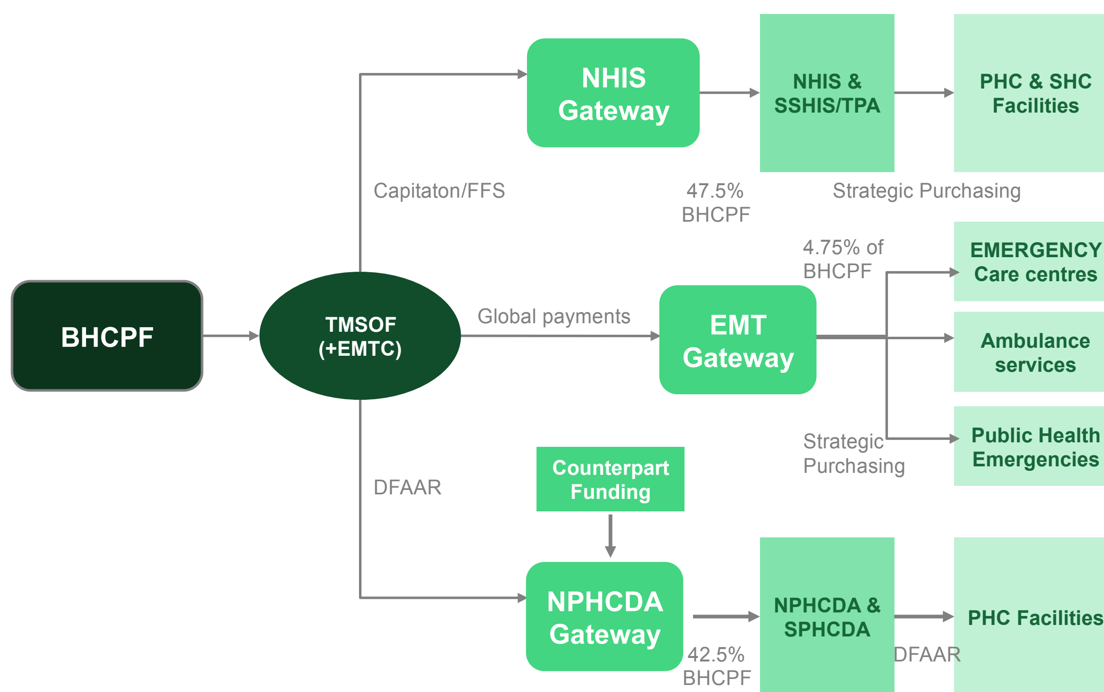

SOURCE:

Figure 6: Disbursement Gateways and Fund Governance

5.4. Verification of Fund Utilisation

I. Independent verification of utilisation of services shall be conducted through Independent Verification Agents (IVAs) using random samples and customer surveys, both from a central call centre and also through home visits.

II. The IVAs will be recruited, appointed, and managed by the TMSOF.

III. Periodic random samples shall be interviewed to verify that care given was appropriate, up to the expected standards and was associated with quality outcomes.

5.5. Provider Payment Mechanisms (PPMs)

i. The Provider Payment Mechanisms (PPMs) adopted for this initiative are based on current, international best-practice. The mechanisms reflect the paradigm shift from "input-based" to "output-based" (results) financing.

ii. The "Global Payments" Provider Payment Mechanism for the NHIS Gateway and the "EMT Gateway" is a modified form of the well-established "Fee-for-Service" payment process. Providers shall be expected to render services and then submit claims for payment retrospectively (on a monthly or quarterly basis).

iii. The "Decentralised Financing for Accountability and Results" Provider Payment Mechanism for the NPHCDA Gateway is a modified form of the more recently established Decentralized Facility Financing" (DFF) or "Results-Based Financing" (RBF) process. Providers are funded prospectively, on a quarterly basis, for operational expenses with both "front-loaded" and "completion-linked" incentive payments.

iv. For the procurement of clinical services, in particular, for the provision of Emergency Medical Treatment, the practice of Strategic Purchasing[15] would be adopted.

5.6. Payment Tariffs

I. A minimum of 95 per cent of the monies accruing to the Fund shall be utilised in the purchase of care. A credible, costed BMPHS for this initiative has been developed through a very rigorous procedure. The tariffs to be paid to providers in the private and public sectors will be determined by professional actuaries recruited by NHIS. The tariffs will be approved by the TMSOF.

II. There are two different payment plans available under the initiative. The NHIS Gateway and EMT Gateways utilise a retrospective, reimbursement system, requiring an explicit fee schedule whereas the NPHCDA is a prospective, stimulatory system, characterised by periodic disbursement of conditional, bulk grants.

III. The NHIS Gateway and EMT Gateways shall fund the BMPHS where providers are able to submit claims for reimbursement for the costs of care given to patients. The Payment Tariff on which decisions on amounts to pay in claims for care to eligible primary and secondary care providers, is outlined below:

INTERVENTION
Antenatal Care (ANC)
Labour & Delivery Care
Emergency Obstetric and Neonatal Care (EmONC)
Caesarean Section
Blood Pressure/Hypertension
Diabetes screening (Urinalysis tests)

Table 3: Unit Intervention Costs for the BMPHS (NHIS Gateway)

IV. The NPHCDA Gateway shall fund Operational Expenses in Primary Healthcare Centres through disbursement of defined, quarterly, bulk conditional grants. This payment structure does not require an explicit or implied Payment Tariff.

[15] "Strategic Purchasing or Commissioning is the planning and purchasing of preventive, curative and rehabilitative clinical services to meet the health needs of a population". Public Ends, Private Means. Strategic Purchasing of Health Services. Precker AS, Liu, X, Velenyi EV, Baris E (Eds). The World Bank Washington DC 2007.

5.7. NHIS Gateway

5.7.1. Benefit Package

The NHIS Gateway shall provide funding to ensure all Nigerians are able to receive the Basic Minimum Package of Health Services (BMPHS) for Nigeria (2016), completely free at the point of delivery, without any user fees whatsoever.
The BMPHS shall consist of nine (9) interventions as defined in the section on services. Broadly, these include ANC, labour & delivery Care, EmONC, clinically indicated elective casesarean section, hypertension screening, diabetes screening, malaria treatment, two (2) for children (curative care and immunization) and emergency medical treatment for RTIs.

5.7.2. Operation of the NHIS Gateway

I. In the first five years (5) of its operation, the NHIS Gateway shall be implemented as a pro-poor programme, with a view to redressing the inequity in access to care experienced by poor, rural dwellers.
II. To improve access and quality of care in rural areas, during the first five (5) years of operation of the Fund, sole preference will be given to healthcare providers situated in Rural Areas.
III. During this initial period, there shall be no funding available from the Fund for healthcare providers in urban areas.
IV. Healthcare providers in rural areas shall be offered maximum assistance for accreditation so that at least "**one healthcare facility per ward**" is able to participate in this initiative.
V. **Sunset Clause:** After this initial period of five years, a fresh set of Guidelines shall be drawn up outlining the terms for the operation of the NHIS Gateway especially on the eligibility of other providers (urban and rural) to be accredited into and join the initiative.

5.7.3. Healthcare Provider

I. Health care providers should expect payment of their invoices within 90 days of their submission to the SSHIS/TPA or equivalent;
II. Healthcare providers have the right to complain and seek redress for issues or problems that arise from the operation of this gateway. The redress mechanism will be operated at the behest of the TMSOF.

5.7.4. Third Party Agents/Administrators (TPAs)

VI. Day-to day operational aspects of the NHIS Gateway shall be carried out by SSHIS/Third Party Agents (TPAs) who shall either be for-profit or not-for-profit organisations; contracted to carry out defined functions and roles on behalf of the TMSOF, NHIS and SPHCDA, by the SFA.
VII. All SSHIS/TPAs shall have the requisite experience in the following areas: (i) Provider Accreditation (b) Claims Management (c) Data Analysis
VIII. The functions and roles assigned to contracted SSHIS or TPAs would include: (i) Accreditation of Healthcare Providers (ii) Provider Management, including Case Management (iii) Fund Management (iv) Call-Centre Operations (v) Service Level Agreements governing such

processes (vi) Liaison between TMSOF, NHIS, SPHCDA and SFA (Regulator Relations) (vii) any other function outsourced to the SSHIS/TPA.

IX. The SFA/SSHIS acting for and on behalf of the NHIS and SPHCDA may procure, appoint and manage TPAs who shall be engaged provisionally for three (3) years in the first instance.

X. At the expiration of the initial three (3) year contract, the contract may be renewed provided there is a favourable assessment of performance of the TPA on designated functions and review of the number of complaints made against the TPA.

5.7.5. Payment Model

I. Accredited healthcare providers who have rendered services shall be paid through the Global Payments Mechanism, which is a modified "Fee-for-Service process.

II. Monthly payments will be made through the SSHIS/Third Party Agents/Administrators (TPAs) to healthcare providers on behalf of the NHIS, based on the number of patients seen and treated.

III. The provider payment model is retrospective, claim-based process outlined in Figure 7.

IV. At the end of each quarter, providers present an invoice(s) to the TPAs who verify the claim. Provided this is valid, the TPA passes the invoice(s) and supporting documents to the SFA/SSHIS, then the TMSOF where the Secretary and the NHIS Representative sign off on the claim. This triggers off a request to the CBN to make the payment directly into the account of the healthcare provider, for services rendered.

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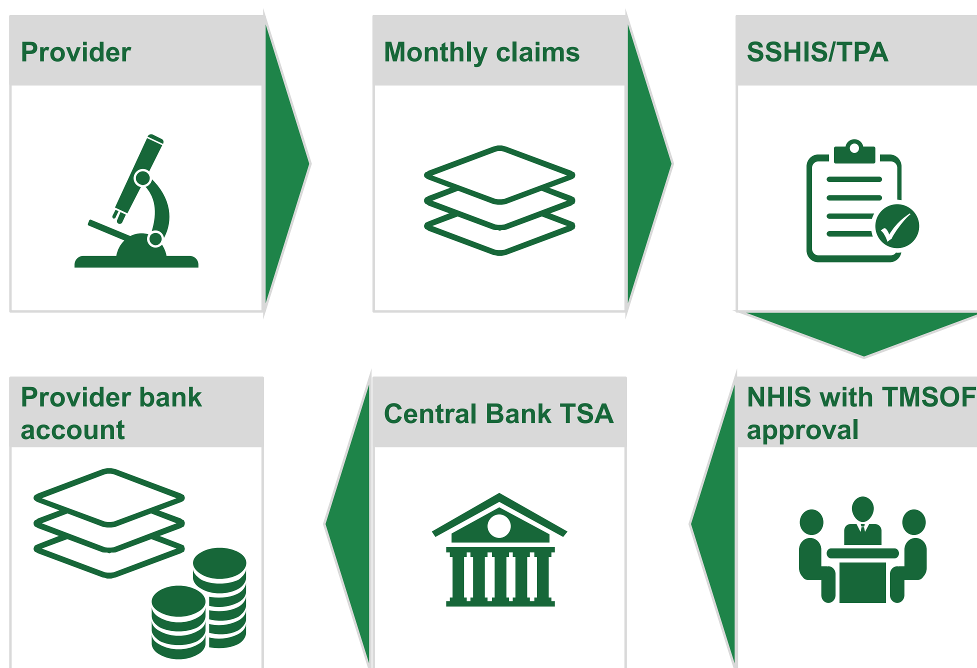


Figure 7: Payment Model for the reimbursement of Providers under the NHIS Gateway

5.8. NPHCDA Gateway

The NPHCDA Gateway shall provide funding to strengthen the delivery of Primary Care across the country by underwriting the Operational Expenses of Primary Healthcare Centres (PHCs). Operational Expenses, including funds required for improvement of facility, basic repairs, procurement of basic supplies, vaccine retrieval from the cold chain store, community outreaches and health promotion activities have traditionally been underfunded, which has undermined the effectiveness and functionality of PHCs.

5.8.1. Operation of the NPHCDA Gateway

I. All States through their **SPHCDAS** shall be entitled to receive equal allocation of resources in any given year.

II. The "Decentralised Financing for Accountability and Results" Provider Payment Mechanism for the NPHCDA Gateway is a modified form of the more recently established Decentralized Facility Financing" (DFF) financing or "Results-Based Financing" (RBF) process. Providers are funded prospectively, on a quarterly basis, for operational expenses with both "front-loaded" and "completion-linked" incentive payments

III. **Sunset Clause:** After this initial period of five years, a fresh set of Guidelines shall be drawn up outlining the terms for the operation of the NPHCDA Gateway especially on the eligibility of other providers (urban and rural) to join the initiative.

5.8.2. Payment Model

The provider payment model is prospective, bulk grant process outlined in Figure 8.
The SFA/SPHCDA shall immediately transfer into the bank accounts of each eligible, empanelled PHC facility, equal sums as a prospective, bulk grants, for operational expenses, as soon as funds are released from the BHCPF CBN TSA sub-account.
The regular funding cycle would be QUARTERLY with the following incentivised schedule:

- **Quarter One:** 40% of allocated funds-released on meeting criteria
- **Quarter Two:** 20% of allocated funds-released as routine
- **Quarter Three:** 20% of allocated funds released as routine
- **Quarter Four:** 20% of allocated funds released on receipt of returns

The Quarter Four disbursement (20% of allocated funds) shall be contingent on receipt by SFA/SPHCDA the validated proof of utilisation status of initial grants to PHCs.

Each SFA/SPHCDAs shall be entitled to an annual bonus if it achieves all the stated targets also publishes its audited accounts by September of the following year. As earlier stated, States that do not meet the requirements for disbursement in any given year shall be deemed to have forfeited the allocation. At the start of each fiscal year, the opening balance for the NPHCDA gateway shall be the rolled-over sums in addition to annual accruals.

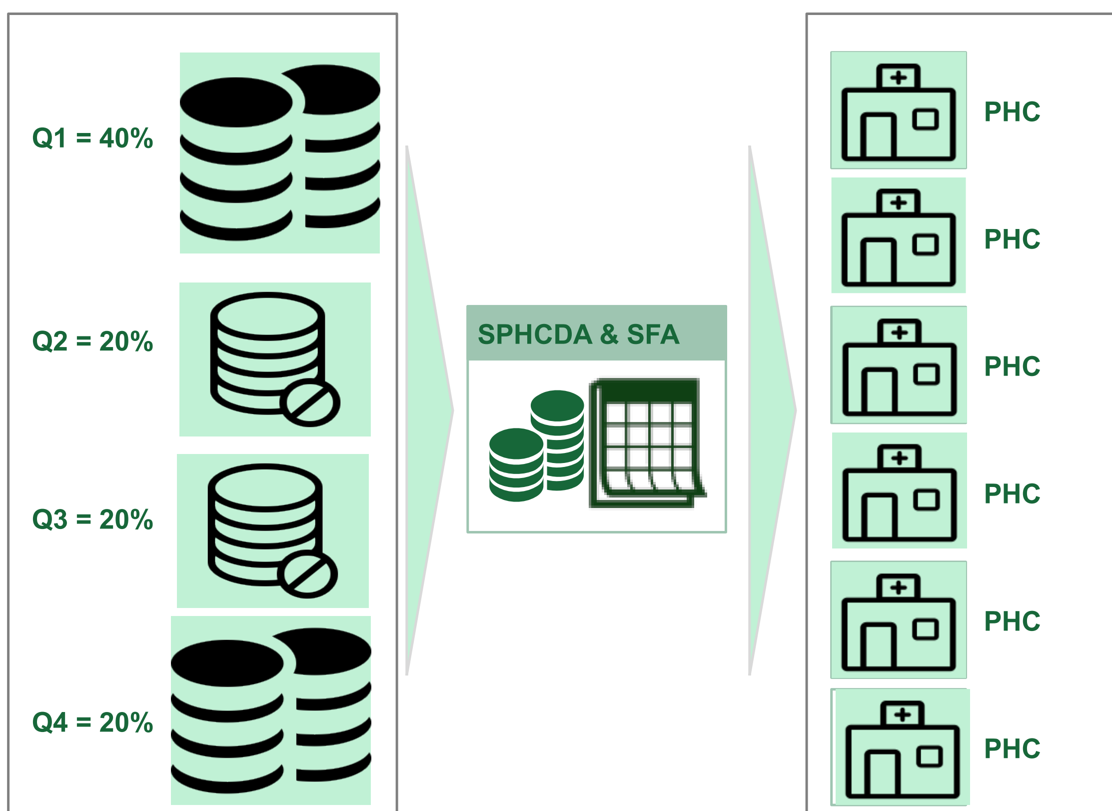


Figure 8: Payment Model for the funding of Providers under the NPHCDA Gateway

5.9. EMT Gateway

5.9.1. Emergency Medical Treatment Package

The EMT Gateway shall provide funding to ensure all Nigerians are able to receive the Emergency Medical Treatment (EMT) component of the Basic Minimum Package of Health Services (BMPHS) for Nigeria (2016), completely free at the point of delivery, without any user fee whatsoever. These services include scene (emergency pre-hospital care), transfer (transportation & communication) and facility (initial evaluation, diagnosis & resuscitation and in-hospital care).

5.9.2. Operation of the EMT Gateway

I. In the first three (3) years of its operation, the EMT Gateway shall be implemented as an INTERVENTION programme, with a view to addressing the excess mortality surrounding fatal Road Traffic Injuries (RTIs) in Nigeria
II. To significantly reduce mortality during the first three (3) years of operation of the Fund, six (6) most dangerous routes in Nigeria, designated "Accident Hotspots[16]" (Table 4) will be targeted with deployment of maximum resources
III. During this initial period, a UNIVERSAL EMERGENCY NUMBER that would be valid throughout the catchment areas, available from every telephone device (landline or

[16] The selection criteria for these Accident Hotspots: Routes with >50 RTI Fatalities in 2015 (data from FRSC Annual Report 2015)

mobile), easy to remember and dial (i.e., limited to 3 or 4 digits) and would be free of charge would be established and launched

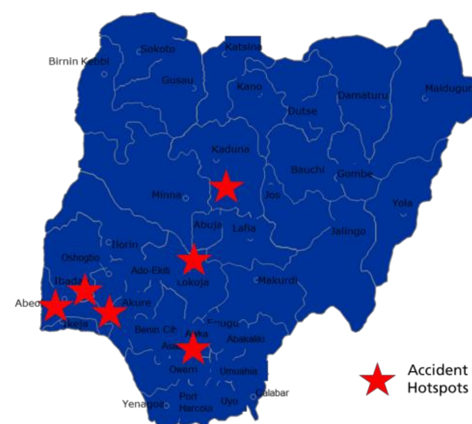
IV. Emergency Care Providers in close proximity (30 km radius) to each of these "Accident Hotspots" will be encouraged to significantly upgrade and improve their capacity and capability and offered maximum assistance for accreditation to participate in this initiative.

V. **Sunset Clause:** After this initial period of five years, a fresh set of Guidelines shall be drawn up outlining the terms for the operation of the EMT Gateway especially on the eligibility of other providers (urban and rural) to be accredited into and join the initiative.

Table 4: Top Six Routes for Road Traffic Injuries Fatalities in Nigeria (2015)

	ROUTE	NO OF RTI FATALITIES (2015)
1	Abuja-Lokoja	293
2	Lagos-Ibadan	154
3	Doka-Kaduna	94
4	Onitsha-Awka	74
5	Lagos-Ore	57
6	Abeokuta-Lagos	51

Source: Federal Road Safety Commission Annual Report 2015



5.9.3. Commissioning of Services

I. Day-to day operational aspects of the EMT Gateway shall be carried out by Healthcare Providers and Facilities who shall either be for-profit or not-for-profit organisations; contracted to carry out defined functions and roles on behalf of the TMSOF, EMTC and FMoH

II. The TMSOF, acting on behalf of the EMTC shall commission (Strategic Purchasing) accredited Ambulance Service Providers nationwide, including the Federal Road Safety Corps (FRSC), State Ambulance Services, National Emergency Management Agency (NEMA), Private Sector Ambulance Service Providers and Voluntary Sector Ambulance Service Providers.

III. The TMSOF, acting on behalf of the EMTC shall commission nationwide (Strategic Purchasing) accredited Healthcare Facility Providers with capacity and personnel for Emergency Initial Evaluation, Diagnosis & Resuscitation and any required basic In-Hospital Care including the Federal Tertiary Centres, State Tertiary Centres, Private Sector Tertiary and Emergency Care Providers and Voluntary Sector Tertiary and Emergency Care Providers

IV. The TMSOF, acting on behalf of the EMTC shall commission nationwide (Strategic Purchasing) Healthcare Providers who shall be engaged provisionally for three (3) years in the first instance.

V. At the expiration of the initial three (3) year contract, the contract may be renewed provided there is a favourable assessment of performance of the Healthcare Provider on designated functions and review of the number of complaints made against the Provider

5.9.4. Payment Model

I. Accredited healthcare providers who have rendered services shall be paid through the Global Payments Mechanism, which is a modified "Fee-for-Service process.

II. Quarterly payments will be made through Third Party Agents/Administrators (TPAs) to healthcare providers on behalf of the TMSOF, based on the number of patients seen and treated.

III. The provider payment model is retrospective, claim-based process

IV. At the end of each quarter, providers present an invoice(s) to the TPAs who verify the claim. Provided this is valid, the TPA passes the invoice(s) and supporting documents to the TMSOF where the Secretary and the EMTC Representative sign off on the claim. This triggers off a request the CBN to make the payment directly into the account of the healthcare provider, for services rendered.

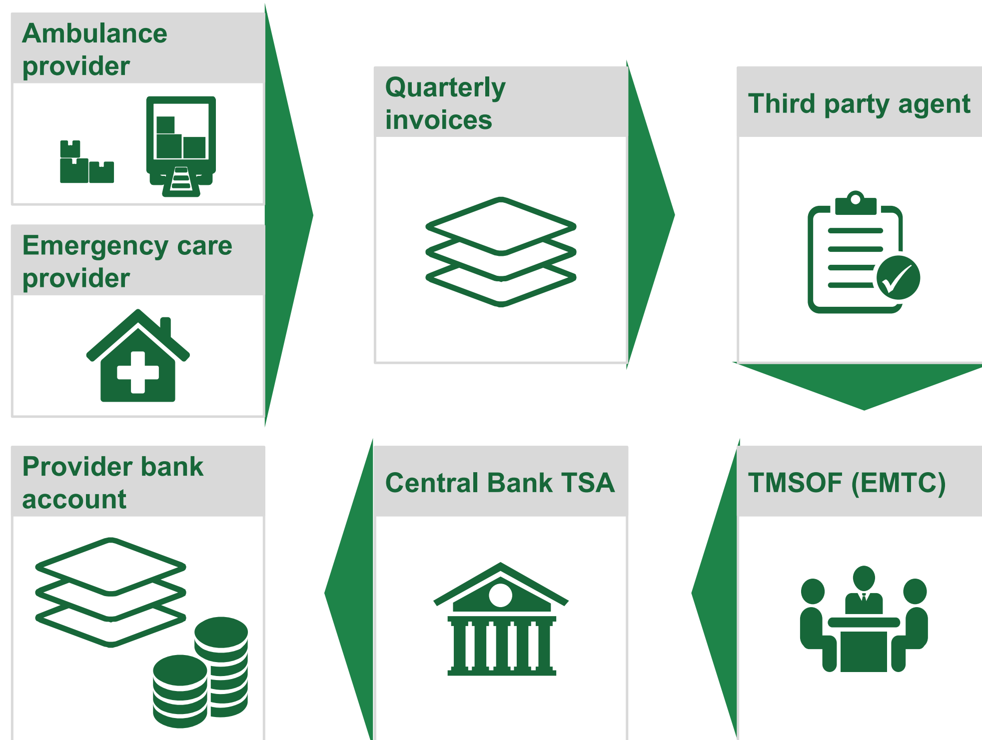


Figure 9: Payment Model for the reimbursement of Providers under the EMT Gateway

6. MONITORING AND EVALUATION OF THE FUND

Monitoring of the fund shall take place based on the administrative, financial, utilization and supervision data at various levels:

i. The NPHCDA Gateway shall be monitored based on disbursement records from facility and State level

ii. The NHIS Gateway shall be monitored based on utilization data at provider level and records of third party administrators

iii. TMSOF performance shall be monitored based on disbursement records and annual reports at federal level

6.1. Monitoring of the NPHCDA Gateway

Monitoring of disbursements shall take place as follows:

6.1.1. Ex-Ante Verification

I. Shall take place prior to the initial disbursement of 40% funds to State Primary Healthcare Development Agencies.
II. Shall provide satisfactory evidence to the TMSOF that all participating States have made a budgetary provision for PHC in their annual budget/appropriation for the disbursement year.
III. Shall take place for 100% of participating States.

6.1.2. Ex-Post Verification:

I. Shall take place following the initial disbursement of 50% of funds to eligible States;
II. Shall provide satisfactory evidence to the TMSOF that:
    a. All participating States have disbursed 100% of funds received to 100% of participating facilities;
    b. Facilities have been given the autonomy to run individual bank accounts, for book-keeping and accounting; and
    c. Facilities have been given the autonomy to expend resources based on needs as determined by the facility management and in accordance with the guidelines set out in the Memorandum of Understanding.
III. Shall take place in least 10 -15% of facilities in 100% of participating states;
IV. Shall be completed no later than end of the 3rd quarter or 30th of September of the disbursement year;
V. Completion of verification shall trigger the disbursement of the second tranche of funds due to the participating SPHCDA from the Fund; and
VI. Non-payment of facilities shall result in withholding of the 2nd tranche of funds as outlined earlier.

6.2. Monitoring of the NHIS Gateway

6.2.1. Provider Accreditation

I. Provider accreditation under these Guidelines shall:

    a. Take place prior to enlistment of primary and secondary providers into the free Maternal and Neonatal Health programme; and

b. Assess a range of basic minimum criteria (described above) required for the provision of the continuum of free MNH services and provide satisfactory evidence to the TMSOF on the suitability of providers to participate in the programme;

II. Providers applying for enlistment into the free MNH programme shall undergo the accreditation assessment.

III. Providers may request a repeat accreditation 2 months after the initial assessment.

6.2.2. Ex-Post Verification of Utilization at Provider Level

I. Ex-post verification of utilization at provider level shall:

a. Take place to provide satisfactory validation to the TMSOF, that the quantum of services reported by health facilities have been actually been rendered.

b. Take place in least 10-15% of facilities in 100% of participating states

c. Be completed no later than one month following the end of each quarter.

II. Completion of verification shall trigger the disbursement of funds to Third Party Administrators who shall in turn, disburse the amounts due to health facilities no later than 8 weeks following the end of the quarter.

6.2.3. Ex-Post Verification of Disbursements by TPAs

I. Shall take place to provide satisfactory validation to the TMSOF that TPAs have, in a timely manner, disbursed payments due to providers for the services rendered in the previous quarter.

II. Shall take place for least 25% of TPAs randomly selected across the participating States and validated for at least 15% of providers in the TPA supervision cluster.

III. Shall be completed no later than one month following the end of each quarter, commencing from the 2nd quarter of the disbursement year.

IV. Completion of verification shall trigger disbursements of administrative fees due to TPAs.

6.2.4. Assessment of Quality of Care at Provider Level

I. Shall take place at least once a quarter for a selected proportion of enlisted providers to provide substantive evidence to the TMSOF that the quality of care offered by providers is satisfactory

II. Shall assess quality domains including but not limited to general and financial management, Essential Drugs Management, Outpatient services, Antenatal services, Prenatal and Postnatal Care and Skilled Birth Attendance

III. Shall take place at two levels:

a. At *PHC Provider level* conducted by the Local Government Primary Healthcare Authority

b. At *Secondary Care Provider level* conducted by the Hospitals Management Board

IV. Shall not be linked to disbursements or provider payments. However, shall attract a penalty as outlined earlier for the provider and TPA in the event that quality standards are found to be below the minimum standard criteria

6.3. Impact Evaluation

I. A rigorous Impact Evaluation (IE) shall be designed to assess the impact of the fund.

II. Conduct of the Impact Evaluation shall be the responsibility of the Federal Ministry of Health with support from the National Bureau of Statistics. The Honourable Minister may request the services of another organization to support the government agencies in design and execution the surveys

III. The Impact Evaluation shall at the minimum, consist of baseline surveys prior or at the time of establishing the fund and an endline survey at the end of the third year of disbursement.

SMART surveys may be used to judge changes in skilled birth attendance and immunization coverage.

IV. The Impact Evaluation shall be designed to measure progress in utilization of key MNH services
    a. Availability, utilization and coverage of key maternal and neonatal health services especially for the poor and,
    b. Reduction in inequities in access and health (related) expenditures
    c. Quality of care, in public and private health facilities
    d. Changes in health seeking behaviour over time

V. The Impact Evaluation shall generate lessons on the effectiveness of the fund. Evidence shall be widely disseminated and inform the review of the guidelines. Data shall be made available to the TMSOF for other key advocacy engagements

MONITORING AND EVALUATION FRAMEWORK							
Type of Monitoring	**Data Source**	**Reporting Tool**	**Responsible Agency/Party**	**Frequency of Measurement**	**Timeline of Assessment**	**Level of Administration**	**Anticipated Output**
GOVERNANCE AND OVERSIGHT							
Outcomes	TBD	Randomized trial	FMOH, NBS		Baseline prior to establishment of the Fund; Endline after three years	Community	Provides population level quantitative data on the key 'indicative' metrics: OPD, OPD-U5, SBA, DPT3; triangulation of routine data
	Survey data	TBD	FMOH, NBS		Baseline prior to establishment of the Fund; Endline after three years	Health facility	Measurement of quality of care in selected facilities.
Fund Management/Administrative	• State Administrative Reports on BHCPF Management • NPHCDA, NHIS activity reports Other sources as stated below	Annual Report	FMOH with NPHCDA, NHIS	Annually		All	Annual report on administration of BHCPF that is widely disseminated amongst stakeholders and publicly disclosed
DECENTRALISED FACILITY FINANCING, AUTONOMY AND ACCOUNTABILITY							
Fund Management	State budget	Verification checklist	TMSOF, NPHCDA arm	One-off per disbursement year	April 30	SPHCDA	Used for verification by TMSOF; triggers decision on tranche 1 payment
	Payment vouchers	Verification checklist	TMSOF, NPHCDA arm	One-off per disbursement year	September 30	SPHCDA, PHC	Used for verification by TMSOF; triggers decision on tranche 2 payment
	• Bank statement • Income and expense statement	Verification checklist	TMSOF, NPHCDA arm	One-off per disbursement year	September 30	Health Facility	Verifies actual payments received by health facilities and that expenditure is in accordance with agreements of MoU
FREE MNH PROGRAMME							
Accreditation	• HF listing (of accredited providers)	Accreditation checklist	TMSOF, NHIS arm	One-off	Before signing of MoU with providers	Public and private providers	Ensures that facilities enrolled in the programme met a basic minimum criteria for the provision of MNH services
Utilization (Ex-ante)	• ICT-based registration forms (as with DFAAR)	Summary invoice based on number of services provided	Third Party Administrator	Quarterly	Data feed is real-time Invoices submitted 2 weeks following the end of the quarter	Public and private providers	Focus on MNCH sub-set of indicators as in DFAAR; add first ANC, 2-4 ANC, PNC indicators as per benefit package (registration form

	PHC Level i. ANC ii. Skilled deliveries iii. PNC iv. Referral *Secondary Level* i. Referral (for assisted deliveries and C-S only) •						captures services accessed)
Utilization (Ex-post)	Patient trace-back (phone) and household visits	Verification and client satisfaction survey tool	Independent Third Party with TMSOF involvement	Quarterly	Health Facility, Community	Verifies that payments are in accordance with # of services delivered by PHC and fees paid for; # of referred cases at secondary; reason for referral is justified	
Grievance Redress	Beneficiary feedback on type and quality of services received at facility; any difficulties in accessing care	Grievance redress form that collates community grievances	Ward Development Committee	Weekly	Health Facility, Community	Resolves any immediate disputes or difficulties in pregnant women accessing care; real-time feedback on patient satisfaction with services	
Provider Payment/Financial Management	• Statement of account • Payment voucher	Verification checklist	TMSOF, NHIS arm	Quarterly		TPA, Provider	Used for verification by NHIS; triggers decision on quarterly FFS payments by TMSOF
Quality of Care	•	Quantified quality checklist	LGA PHCA or other	Quarterly		Provider	Ensures maintenance of minimum quality standards at provider level

7. ANNEX: Monitoring of the Fund

7.1. Monitoring of the NPHCDA Gateway

7.1.1. Ex-Ante Verification Mechanism

I. States shall submit to the TMSOF, no later than 30th March of each year, State budgets for health that evidences appropriation for Primary Healthcare
II. Budgets shall also be publicly disclosed on the website of either the State Government, its Ministry of Health or State Primary Healthcare Development Agency
III. States shall be required to submit quarterly reports of utilization data for key indicators, including outpatient visits (including for children under-five), antenatal visits, skilled deliveries, postnatal visits and immunization
IV. The TMSOF or its designated team shall assess submitted budgets and approve or deny eligibility of States no later than two weeks following the end of the first quarter of the disbursement year
V. The TMSOF shall disburse funds to eligible States no later than one month following the end of the first quarter of the disbursement year

7.1.2. Ex-post Verification Mechanism

I. TMSOF shall use the sampling frame of all participating facilities to randomly select at least 15% of facilities as targets for the verification exercise
II. *At State level,* Independent Third Party (ITP) shall use the designated verification checklist to assess the following:
    a. Statement of accounts to ascertain the date of receipt of funds from the Fund (Federal Level).
    b. Payment vouchers for evidence of disbursement of funds to facilities no later than one month following the SPHCDA's receipt of the first tranche of funds from Federal level.
    c. States shall be encouraged to submit quarterly reports of utilization data for key indicators including outpatient visits (including for children under-five), antenatal visits, skilled deliveries, postnatal visits and immunization.
III. *At facility level* ITP shall:
    a. Establish from facility bank statements a triangulation, that amounts due to health facilities from SPHCDA were received as due no later than one month following the SPHCDA's receipt of the first tranche of funds from Federal level.
    b. Establish from facility's income and expense statements that health facilities have expended resources in accordance with pre-defined guidelines as outlined above and as agreed in the Memorandum of Understanding signed with the State.
IV. Verification reports shall be collated for the State, by the ITP and be submitted to the TMSOF no later than the end of the third quarter of the disbursement year
V. The TMSOF shall review and approve or deny funds due to States, based on the submissions, no later than two weeks following the end of the third quarter of the disbursement year
VI. The TMSOF shall disburse funds to eligible States no later than one month following the end of the third quarter of the disbursement year
VII. States defaulting on payments to facilities shall be subject to penalties as outlined in Annex 8.

7.2. Monitoring of the NHIS Gateway

7.2.1. Provider Accreditation Mechanism

- The TMSOF shall commission an accreditation team to conduct the assessment for all applicant providers
- Accreditation teams shall visit the applicant providers and conduct assessments based on the basic minimum criteria as contained in the designated accreditation checklist
- Accreditation teams shall submit to the TMSOF, a collated list of assessed and eligible providers for approval
- The TMSOF shall approve or deny eligibility of providers and designate them to a cluster under the management of a Third Party Administrator

7.2.2. Mechanism for Ex-Post Verification of Utilization at Provider Level

I. Participating health facilities shall report services rendered routinely and on a real-time basis using the designated smart phone application:
   a. *At primary level:* Antenatal Visits (First, Standard i.e. 4+), Normal Delivery, Post-natal visit
   b. *At secondary level:* Assisted deliveries, Caesarean Sections
   c. Data shall contain complete bio-data of beneficiaries, including name, telephone number, address and relative's contact details
   d. ITP shall on a quarterly basis, no later than two weeks following the end of the quarter, aggregate data on the services rendered and submit invoices for the total quantum of services rendered by individual facilities, for the cluster of facilities:
   e. *At primary healthcare level*: a service rendered shall be defined as the continuum of four or more antenatal visits, delivery attended by skilled personal and a post-natal visit within 48 hours of delivery
   f. *At secondary healthcare level*: a service rendered shall be defined as an assisted delivery or caesarean section referred from an eligible primary healthcare facility

II. The TMSOF designated ITP shall randomly select, from a sampling frame of all eligible facilities, a sample of up to 15% of health facilities for verification

III. The verification team shall make phone calls to trace back beneficiaries, verify the service they assessed from the health facility and elicit their perception on the quality of care for no less than 1% of beneficiaries. The verification team shall trace back beneficiaries in person, at community level, via household visits for no less than 25% of the selected sample

IV. The report of verification shall be submitted by the ITP to the TMSOF no later than one month following the end of the quarter

V. The TMSOF shall approve disbursements due to TPAs no later than one month following the end of the quarter

VI. Disbursements shall be withheld for services not verifiable by the ITP. In addition, a high degree of discordance (greater than 25%) between services reported and services verified will attract a penalty as outlined in Section x

7.2.3. Mechanism for Ex-Post Verification of Disbursements by TPAs

TMSOF designated ITP shall randomly select 25% of TPAs as targets for the verification exercise. Within the selected TPA clusters, TMSOF shall randomly select 15% of providers.

I. Verification teams shall conduct assessments of the records of TPAs to ascertain that disbursements have been made as and when due to providers. Accordingly, they shall review the following:
   a. Statement of accounts to ascertain the outflow of funds from the TPA to the provider.

b. Payment vouchers as supporting evidence of disbursement of funds to facilities.

II. *At provider level* verification teams shall assess the following:

a. Establish from facility bank statements, a triangulation that amounts due to providers were received as due, no later eight weeks following the end of the quarter.

b. Verification reports shall be collated by the ITP and submitted to the TMSOF no later than one month following the end of the quarter.

III. The TMSOF shall, in the instance of defaulted payments by the TPA, apply the penalties as described in Annex 8.

7.2.4. Mechanism for Assessment of Quality of Care at Provider Level

At PHC provider level

I. The Local Government Primary Healthcare Authority (LGA PHCA) shall take a sample of up to 25% of enlisted PHC providers every quarter

II. The LGA PHCA shall visit the sampled PHC to assess the quality of care by administering the TMSOF designated quality checklist. LGA PHCA shall provide feedback to providers on improvements required at the point of administration

III. The quality assessment reports and scores shall be collated by the State/Zonal focal person for the NHIS gateway and submitted to the TMSOF no later than one month following the end of the quarter

IV. Any providers found to have sub-standard quality scores shall be penalized. For repeat infractions, TPAs will also be penalized along with providers.

At Secondary Care

I. The HMB shall take a sample of up to 25% of enlisted secondary care providers every quarter

II. The HMB shall visit the sampled secondary facilities to assess the quality of care using the TMSOF designated quality checklist. HMB shall provide feedback to providers on improvements required at the point of administration

III. The quality assessment reports and scores shall be collated by the State/Zonal focal person for the NHIS gateway and submitted to the TMSOF no later than one month following the end of the quarter

IV. Any providers found to have sub-standard quality scores shall be penalized. For repeat infractions, TPAs will also be penalized along with providers.

7.2.5. Monitoring the Performance of the TMSOF

- The assessment team designated by the Honourable Minister of Health shall review the records of activities of the TMSOF using a designated checklist follows:
  - (i) ITP are commissioned and mobilized no later than one month prior to the relevant completion deadline
  - (ii) Statement of accounts shall provide evidence that the first tranche of payments due to the SPHCDA through the NPHCDA Gateway have been duly effected before the end of the first quarter of the disbursement year

or

That the second tranche of payments due to the SPHCDA under the NPHCDA Gateway have been duly effected before the end of the third quarter of the disbursement year

(iii) Payments due to TPA and provider through the NHIS Gateway are effected no later than 6 weeks following the end of each quarter

(iv) Utilization and quality data generated from NHIS Gateway providers is analysed and publicly disseminated every quarter with feedback to TPA for disclosure to assessed facilities

(v) Mid-term report submitted no later than the end of the first month of the third quarter of every year and annual report and audit submitted no later than the end of the first month of the second quarter of the subsequent year

- The assessment team shall provide a performance assessment report to the Honourable Minister on the performance of the TMSOF the end of the first month of the second quarter or end of the first month of the third quarter of the disbursement year
- The Honourable Minister shall approve or deny a performance bonus for the TMSOF

8. ANNEX: PENALTIES

Where established via a verification report, penalties shall be applied for the following infractions:

8.1. Non-payments to health facilities by SPHCDA

I. Verification team establishes that disbursements have not gone from states to facilities in part or full. This includes part payments of funds due to facilities or payments only to a proportion of enlisted health facilities.
II. This may be intentional, due to unforeseen limitations at State level, poor records at State or facility level or administrative errors.
III. Penalties applied will be dependent on the proportion of facilities that did not receive funds from the SPHCDA as per the verification report.
IV. Subsequent infraction or non-payment to over 25% of facilities will lead to suspension of the participating State.
V. A 10% margin of error is allowed to account for administrative errors and other events beyond the control of the SPHCDA.

8.2. Non-payments to providers by TPA

I. Verification team establishes that payments have not been made by TPA to providers in a timely manner. This includes part payments of funds due to facilities or payments only to a proportion of enlisted providers.
II. This may be intentional, due to unforeseen limitations in TPA payment systems, absence of records, poorly kept records or administrative errors.
III. Penalties applied for payment to less than 25% will result in withholding a commensurate percentage of TPA administrative fees in the first infraction.
IV. Subsequent infraction or non-payment to over 25% of facilities will lead to suspension of the contract of the TPA. A repeat infraction for greater than 25% will result in termination of TPA contract.
V. A 10% margin of error is allowed to account for administrative errors and other events beyond the control of the SPHCDA.

8.3. Services rendered by providers unverifiable

I. Verification team establishes that not all services rendered as reported by providers are traceable. This may be due to poor patient registration records, change in patient contact details (phone number, address), intentional false reporting by provider in the form of 'ghost patients' or claiming more services than the patient assessed or verifier error.
II. Penalties applied for payment to less than 25% will result in withholding a commensurate percentage of payment due to providers on the first infraction. Subsequent infractions will lead to withholding 50% of fees and thereafter suspension of the provider.
III. A discordance of greater than 25% will results in withholding payments due to providers in part on the first office. On the second offence, providers will be suspended from the scheme and lose their accreditation on the third offence.
IV. A 10% margin of error is allowed to account for administrative errors and other events beyond the control of the provider.

8.4. Sub-standard quality of care at provider level

I. Verification team establishes that not all services rendered as reported by providers are traceable. This may be due to poor patient registration records, change in patient contact details (phone number, address), intentional false reporting by provider in the form of 'ghost patients' or claiming more services than the patient assessed or verifier error.

II. Penalties applied for payment to less than 25% will result in withholding a commensurate percentage of payment due to providers on the first infraction. Subsequent infractions will lead to withholding 50% of fees and thereafter suspension of the provider.

III. A discordance of greater than 25% will results in withholding payments due to providers in part on the first office. On the second offence, providers will be suspended from the scheme and lose their accreditation on the third offence.

IV. A 10% margin of error is allowed to account for administrative errors and other events beyond the control of the provider.

8.5. Quality assessed by the LGA

I. In the event that the quality of care is assessed to be below 50%, providers shall on the first infraction, receive a warning with a copy to the supervising Third Party Agent. On the second infraction, the provider contract shall be suspended. On the third infraction, provider accreditation will be withdrawn

II. TPA shall be penalized in the event that over 25% of providers within their supervision cluster are assessed to have a quality score of less than 50%. On the second infraction, TPA contract shall be suspended for one quarter and terminated on the third infraction

TABLE 4: PENALTIES FOR INFRACTIONS ON ACTIVITIES RELATED TO DISBURSEMENT OF THE FUND

	Administering Agent/Recipient	*Degree of discordance*	*Penalties*
NPHCDA GATEWAY	State Primary Healthcare Development Agencies	Verification reveals that between 10% - 25% of facilities did not receive funds due to them	1st Default: • Withdrawal of 10 percent of state funds pro-rated for the degree of discordance 2nd Default: • State is suspended for release of 2nd tranche of funds or 1st tranche of funds in the subsequent disbursement year
		Verification reveals that greater than 25% of facilities did not receive funds due to them	1st Default: • State is suspended for release of 2nd tranche of funds or 1st tranche in the subsequent disbursement year
NHIS GATEWAY	Third Party Administrators	Verification reveals that between 10% - 25% of facilities did not receive funds due to them	1st Default: • Withdrawal of 10 percent of administrative funds due to TPA, pro-rated for the degree of discordance 2nd Default: • TPA is suspended for release of administrative fees due for the next quarter
		Verification reveals that greater than 25% of facilities did not receive funds due to them	1st Default: • TPA is suspended for release of administrative fees due for the next quarter 2nd Default • TPA contract terminated
	Providers: Quantum of Services Rendered	Verification reveals that between 10% - 25% of reported services rendered could not be verified	1st Default: • Withdrawal of 10 percent of payments due to provider in the next quarter, pro-rated for the degree of discordance 2nd Default: • 50% of fees due to the provider are withdrawn in the next quarter 3rd Default Provider is suspended and ineligible to receive payments for the next quarter
		Verification reveals that greater than 25% of reported services rendered could not be verified	1st Default: • 50% of fees due to the provider are withdrawn in the next quarter 2nd Default • Provider is suspended and ineligible to receive payments for the next quarter 3rd Default • Provider accreditation withdrawn
	Providers: Quality of Services Rendered	Quality assessment reveals a quality score of less than 50% for less than 25% of the sampled facilities	1st Default • Warning letter to provider 2nd Default • Suspension of provider and warning letter to TPA 3rd Default • Withdrawal of accreditation of providers and suspension of TPA

Quality assessment reveals a quality score of less than 50% at greater than 25% of the provider facility	1st Default • Warning letter to providers and suspension of TPA 2nd Default • Suspension providers and of TPA 3rd Default 3rd Default • Withdrawal of accreditation of providers and termination of TPA