

Progress towards the Abuja target for government spending on health care in East and Southern Africa

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Executive summary

African Heads of State committed themselves at a meeting in Abuja in 2001 to devoting a minimum of 15% of government funds to the health sector in order to address the massive burden of ill-health facing countries in Africa, particularly within the context of a growing burden of HIV, AIDS, TB and malaria. This report considers progress towards this target and is based on information provided by researchers in various Southern and East African countries.

The report is implemented within the Regional Network for Equity in Health in East and Southern Africa (EQUINET). It draws on various sources of data, including data provided by researchers from nine Southern (Malawi, Namibia, South Africa, Zambia and Zimbabwe) and East (Kenya, Uganda) according to an agreed template, complemented by qualitative data on the Abuja Declaration in national debates and discourses. Limitations are noted in the completeness of the data.

Of the countries reviewed, only Zambia and Malawi have made considerable progress towards the Abuja target, with the health sector's share of total government expenditure increasing consistently from 8% and 5% respectively in 1997 to nearly 11% and 7% in 2000 and almost 18% and 11% in 2003 (thus exceeding the Abuja target in the case of Zambia). Although Namibia has not achieved the Abuja target, it has made good progress from 10% in 1997 to nearly 14% in 2003. Kenya is the furthest from the Abuja target, with only 5% of government resources going to health services in 2006 and with no consistent increase in government spending.

Allocations to the health sector have fluctuated in some countries, such as in Uganda which started from a very low base of over 4% in 1997 and increasing dramatically to nearly 17% in 2000 but falling back to below 12% in 2003 and 2006. This was similar to Zimbabwe which started at 17% in 1997, dropped to just over 7% in 2000 and increased to 9% in 2003. It is concerning that allocations to the health sector in South Africa have been gradually declining from over 13% in 1997 to 11% in 2006.

This research demonstrates that some seven years after the Declaration, many of the countries are still lagging well behind this target, although there are promising signs of increases in allocations towards the health sector in some countries.

One constraint identified is continued spending on debt. The report shows evidence that debt relief in Malawi is likely to have contributed substantially to the country's steady progress towards the Abuja target. There is also limited evidence that while external financing accounts for extremely high shares of total health spending in some countries, increased external financing has not been associated with falling shares of government spending on health, and in fact the opposite has occurred.

The slow pace of incremental shifts in government allocation towards the health sector demands sustained advocacy and monitoring to translate these shifts into attainment of the Abuja commitment of 15%. Although there has been some advocacy from government, parliament and civil society within Southern and East African countries around the target, and some at regional level, it has been relatively limited. If progress is to be made in addressing the heavy burden of ill-health in African countries, health officials, parliamentarians and civil society groups need to monitor and advocate far more effectively around implementation of the Abuja commitment. This is particularly necessary given reported opposition to the Abuja target expressed by AU Ministers of Finance at their recent meeting.

We argue that public advocacy for the target has a number of bases that need to be further developed:

- i. The achievement of 15% government spending on health in some countries in the region signal the feasibility of reaching the target. There is need to demonstrate the health and health systems gains from this. For example other work in EQUINET shows that equitable resource allocation is more likely where domestic health budgets are increasing.
- ii. The need for substantial additional domestic resources to address the growing health needs associated with HIV/AIDS, TB, malaria and other diseases continues to be a primary motivation. Advocacy can demonstrate the importance of domestic spending to support national leadership and capacities to absorb external funding for these areas.
- iii. Advocacy can also highlight how those low- and middle-income countries that have achieved universal health care coverage have demonstrated a major and consistent commitment to prioritising social sectors in government funding.
- iv. Part of the campaign for the commitment should include ensuring access to consistent, quality and timely data on health care spending, to support monitoring on progress.

The demand for 15% of government resources to be devoted to the health sector is not unrealistic in the context of spending levels in countries with strong health systems. Concerns of those who resist increased spending on health, such as finance ministers, must be confronted head-on. If health systems are to be national (nationally determined and managed), comprehensive (with adequate financing across all priority health needs), universal (covering and accessible to all) and people centred (empowering, ensuring inclusion and not raising barriers to health care), then this report signals the relevance of meeting the full scope of the 2001 declaration:

- African countries to mobilise domestic resources for health (15% now);
- unencumbered by debt servicing (Debt cancellation now); and
- supported by ODA (0.7% GNP to ODA now).

1. Background

In 2001, in Abuja Nigeria, Heads of States of the African Union member states committed to allocating at least 15% of annual budgets to the improvement of the health sector, and called simultaneously upon donor countries to complement these resource mobilisation efforts by fulfilling the yet to be met target of 0.7% of their GNP as Official Development Assistance (ODA) to developing countries and cancelling Africa's external debt in favour of increased investment in the social sector. They further resolved to take immediate action to use tax exemption and other incentives to reduce the prices of drugs and all other inputs to health care services for accelerated improvement of population health in Africa (AU Heads of state, Abuja, Federal Republic of Nigeria, 27 April 2001).

In 2004, US\$4.1 trillion was spent on health globally (WHO, 2007a). However 90% of this expenditure was spent by the 30 Organisation for Economic Co-operation and Development (OECD) member countries, which comprise less than 20% of the global population. Despite having 10% of the world's population, 25% of the global disease burden, 60% of the people living with HIV, and the highest disease burden for TB and malaria in the world, Africa accounts for less than 1% of global health spending and contains only 2% of the global health workforce (Atim, 2006). The yawning gap between disease burden and the resources required to address health needs provided the impetus for African Heads of State and the African Union to commit to the Abuja Declaration in 2001.

The Abuja commitment has since been referred to and restated on various platforms (AU, 2007). In 2006, the African Union renewed its commitment to meeting the 15% target at the Special Summit on HIV/AIDS, Tuberculosis and Malaria, particularly in light of the fact that barring a few exceptions, many countries have lagged behind their commitment (AU, 2006). The relevance of this commitment was reiterated at a recent Conference on poverty of the Southern African Development Community, taking the significant economic costs of HIV, TB and malaria into account (SADC, 2008). Hence while there is unpublished report of some weakening commitment amongst Ministers of Finance in the Region to the specific level of 15% government spending (Loewenson and McIntyre, 2008), this commitment made by the heads of state in Abuja appears to have been a popularly endorsed position within and beyond the region.

By 2008, seven years later, Nobel Peace Prize Winner Archbishop Desmond Tutu, Honorary Chair of the 'Africa Public Health Alliance 15% Now Campaign' urged African Heads of State and Government not to in any way revise, drop or further delay implementing the Abuja April 2001 commitment. In a statement to mark the anniversary of the 15% pledge he stated:

"The AU Abuja 15% pledge is one of the most important commitments African leaders have made to health development and financing, and our Heads of State should strive to meet this pledge without further delay. The continued loss of millions of African lives annually which can be prevented is unacceptable and unsustainable. Our leaders know what they have to do. They have already pledged to do it. All they have to do now is actually do it. This is all we ask of them."

This review seeks to evaluate the progress in east and southern Africa towards implementing the Abuja commitment, with a more detailed focus on selected Southern (Malawi, Namibia, South Africa, Zambia and Zimbabwe) and East (Kenya and Uganda) African countries. It is implemented within the Regional Network for Equity in Health in East and Southern Africa (EQUINET), which has adopted the 'Abuja plus' package, reflecting the full scope of the 2001 declaration and thus calling on:

- African countries to mobilise domestic resources for health (15% now);
- unencumbered by debt servicing (debt cancellation now); and
- supported by ODA (0.7% GNP to ODA now).

The call for cancellation of African countries' debt, which recognises the diversion of resources from social spending to debt servicing, is critical. By 2003, debt servicing exceeded health spending in five countries in East and Southern Africa (ESA) (EQUINET SC, 2007). Over the past three decades, ESA countries paid an average US\$14 per capita annually in debt servicing, for many more than their average per capita spending on health (UNDP, 2002). Relief from debt payments releases a sizeable share of government resources to reprioritise towards health.

Even if countries achieve the Abuja 15% target, there remains a substantial gap of about US\$19 billion required for funding health services. This calls for international community external funding support, and builds on the commitment made in OECD countries to contribute 0.7% of their GNP as ODA (African Union, 2005). A recent analysis of aid suggests that excluding debt relief for Nigeria, real levels of aid to sub-Saharan Africa rose by only 2% in 2006, that average contributions of 0.3% of GNP fell well below the UN-agreed target of 0.7% of GNP, and that in 2006 only Sweden, Luxembourg, Norway, the Netherlands and Denmark met the commitment to 0.7% of GNP to ODA (OECD DAC, 2007).

The review explores these three dimensions of the Abuja commitment further, within the demographic and socio-economic context of each country and its overall health care financing and expenditure patterns.

1.1 Background evidence on trends and issues in meeting the Abuja commitment in ESA

The 2000 WHO World Health Report estimated that US\$60 per capita was needed for a comprehensive health system, including a minimally adequate set of interventions and the infrastructure to deliver them (Dodd and Cassels, 2006). In 2001, this estimate was revised to US\$80 per capita per year (Evans et al, 2001). Very few East and Southern African countries have health care expenditure anywhere near that level (see *Table 1*), with the notable exception of relatively 'wealthier' countries like Botswana, Mauritius, Namibia, Seychelles, South Africa and Swaziland. Government funding levels are even lower, given the heavy emphasis on out-of-pocket payments (which is a health care funding mechanism that only benefits those with the ability to pay these charges) in many African countries. It should be noted that the WHO estimates of health care expenditure as presented in *Table 1*, combine domestic tax and other government revenue with external donor funding in their estimates of government expenditure. Thus, the amount of health care funds devoted by national governments is even lower than suggested by the WHO data.

Within the context of very high poverty levels within African countries, the international consensus that pre-payment financing mechanisms should predominate (as opposed to out-of-pocket payments) and the very limited health insurance coverage, government funding has to be the core of health systems.

Table 1: Overview of key health care expenditure indicators, 2004

	Per capita total expenditure on health at average exchange rate (US\$)	Per capita total expenditure on health at international \$ rate	Per capita government* expenditure on health at average exchange rate (US\$)	Per capita government* expenditure on health at international \$ rate
Angola	26	38	20	30
Botswana	329	504	207	317
Burundi	3	16	0.8	4
Kenya	20	86	9	37
Lesotho	49	139	42	117
Madagascar	7	29	4	17
Malawi	19	58	14	43
Mauritius	222	516	122	282
Mozambique	12	42	8	29
Namibia	190	407	131	281
Rwanda	16	126	9	72
Seychelles	534	634	403	478
South Africa	390	748	158	302
Swaziland	146	367	93	234
Tanzania	12	29	5	12
Uganda	19	135	6	44
Zambia	30	63	16	34
Zimbabwe	27	139	13	64

* Note: WHO includes domestic government and external donor funding in their measure of 'government' expenditure

Source: WHO, 2007c

It is difficult to find a 'gold standard' for the share of government resources to devote to the health sector. It is recognised that Ministries of Finance face difficult choices in determining the allocation of government funds between sectors. It is also recognised that spending on other social sectors (such as education and social welfare) have positive health benefits.

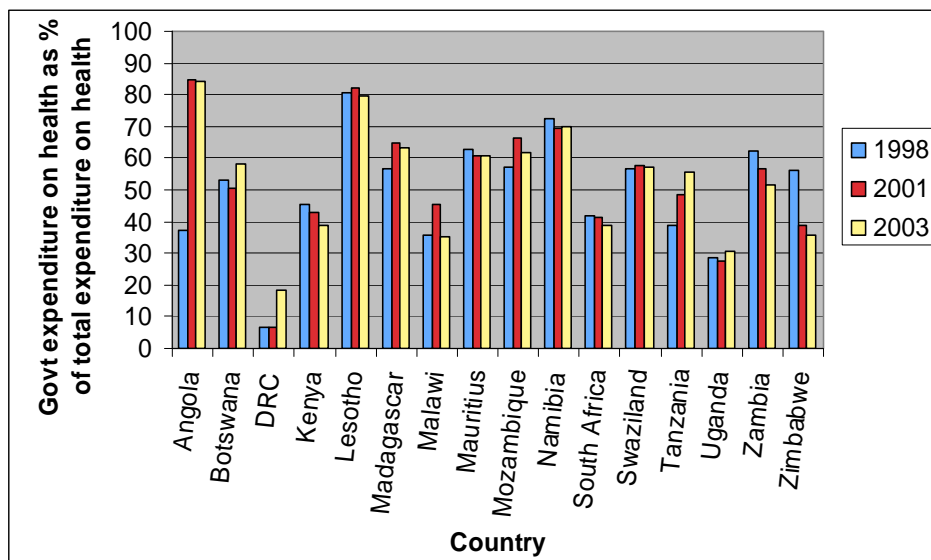
Notably, however, most high-income countries devote a level of 15% or more of government resources to health care. For example, 19% of government resources are devoted to health care in Australia, Switzerland and the United States of America; 18% in New Zealand and Norway; 17% in Canada, Germany, Ireland and Japan; 16% in the United Kingdom; and 15% in France, Portugal and Spain (WHO, 2007c). A growing number of low- and middle-income countries outside Africa are devoting comparable levels of government resources to health care. This is especially the case where there is a strong government commitment to providing publicly funded social services and where universal health care coverage has been achieved. For example, 21% of total government resources are devoted to the health sector in Colombia, Costa Rica and El Salvador; 19% in Guatemala; 15% in the Czech Republic and Paraguay; and 14% in Brazil (WHO, 2007c).

The Abuja target of allocating 15% of government resources to the health sector is thus not unrealistic. Indeed, it is a fair reflection of a minimum level of government funding necessary to achieve universal health care coverage. Universal coverage has been defined in WHO publications as all citizens having access to adequate health care at an affordable cost (Carrin and James, 2004). African countries, along with other WHO member states, have in a recent World Health Assembly resolution called for universal health systems (WHO, 2005).

While it is not expected that governments will achieve the 15% target in the short term, it is an important indicator against which to measure the extent of government commitment to devoting additional resources to meeting the health Millennium Development goals, to addressing the rapidly growing needs associated with HIV and AIDS, TB, malaria and other public health issues through sustainable health systems and to pursuing universal coverage of health care – all commitments made by states to their populations and in regional and international forums.

It should be stressed that the 15% target relates to domestic government funding and **not** a combination of donor and domestic government funding. The falling overall share of government funding of total health funding in some countries in the region shown in *Figure 1* is of concern.

Figure 1: Government expenditure as a % total expenditure on health, ESA, 1998-2003



Source: WHO, 2006

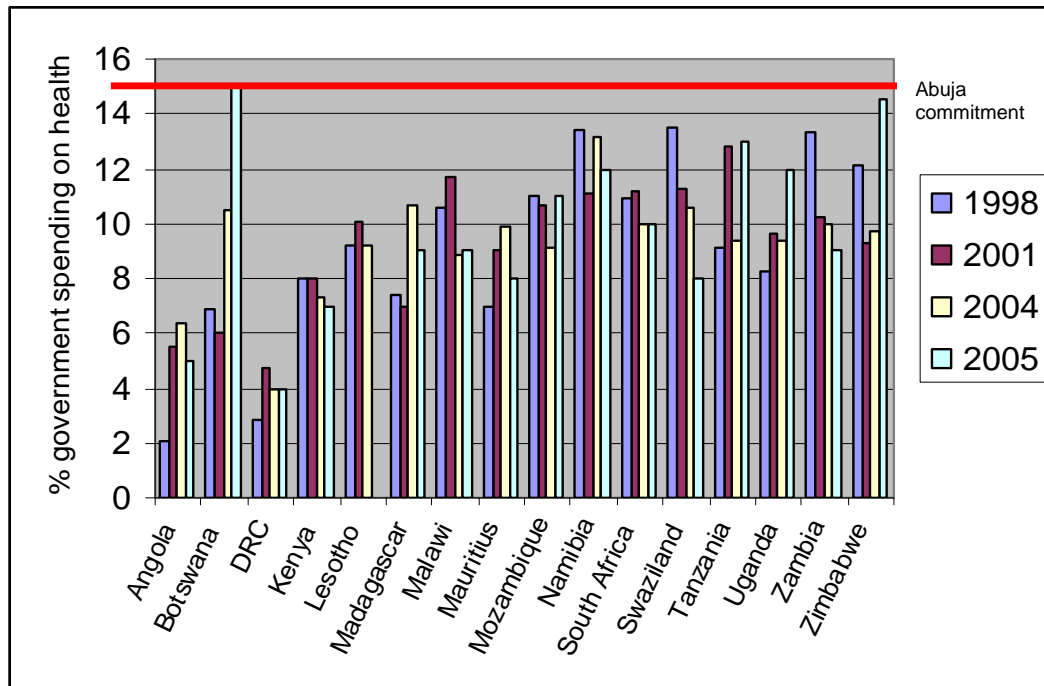
While donors are an important funding source in many African countries, donor funding is often unreliable and unsustainable in the long term. Increasing external and private resources in health does not imply that there can be a *reduced* level of public sector commitments. Indeed, where both private and external resources are growing, there is an even greater need for a strengthened public sector in health to co-ordinate and provide leadership to other sectors and providers, facilitate the redistribution of resources, and to engage with and manage global pressures and local elites. It is politically and technically easier to assert leadership and redistribute health care resources when the overall health budget is increasing, and when there are adequate competent people within the health system (Gilson et al, 2007).

Thus, the emphasis should be on promoting a gradual growth in the relative allocation of government funds to the health sector in order to achieve universal health care coverage based on a stable foundation of public sector funding and increasing reliance on domestic funds over time.

Existing background data shown in *Figure 2* suggests that in 2001, when the Abuja commitment was made, total government spending on health was below 10% for most ESA countries and had fallen since 1998. By 2004, while health spending as a share of government spending had risen in five countries, it had also fallen in eleven. By 2005

evidence presented to the AU reported that while five countries in ESA had increased their levels of health spending, only one country met the commitment (Botswana) and an equal number (Angola, DRC, Kenya, Mauritius and Swaziland) continued to commit 8% or less of their government budgets to health - half the amount committed to in Abuja (Atim, 2006). Further, it is not always clear that external funds are excluded from these reported figures.

Figure 2: Health as a share (%) of government expenditure in ESA, 1998-2005



Source: WHO, 2006; 2005 data from AU reported in Atim, 2006

Hence, using WHO data and data reported to the AU, while some countries (e.g. Uganda, Botswana, Mozambique, Tanzania and Zimbabwe) have begun to take significant steps towards the Abuja commitment, others appear not to. In 2003, for eight of the sixteen ESA countries, if they met the Abuja target their public financing to health would rise above the WHO defined level of US\$60 per capita (EQUINET SC, 2007). While meeting the Abuja commitment does not fill the absolute financing shortfall for some countries, it does move towards this goal, and indicates a prioritisation of health in public spending that is important to lever private and international financing for health, and to redress high levels of out-of-pocket spending from poor households.

This background evidence cited from publicly available data draws on databases that are sometimes incomplete, do not adequately clarify whether the health share reported includes or excludes external spending channelled through government, and do not always link databases drawn from population surveys in the same year to relate health spending to socio-economic or health data. It can therefore give a misleading impression of prioritisation of government resources. The work in this report thus sought to better understand the trends and issues in meeting the Abuja commitment, examining spending on health and debt in the context of demographic, socio-economic, overall health care financing and expenditure patterns in selected countries in ESA.

2. Methods

Researchers from nine Southern (Malawi, Mozambique, Namibia, South Africa, Zambia and Zimbabwe) and East (Kenya, Uganda and Tanzania) African countries were approached to assist with gathering and compiling the data for this report according to a set format (see acknowledgements on contents page for those who ultimately contributed data). A data template was provided and contributors were requested to gather data on selected health care expenditure and economic indicators for specific years (1994, 1997, 2000, 2003 and 2006). The data template was reviewed and input made by selected members of the EQUINET steering committee. These particular years were selected in order to determine whether governments and donors have prioritised health expenditure since the Abuja Declaration. Researchers were requested to collate data from official domestic sources (e.g. Ministry of Health expenditure statements) to ensure accuracy. As indicated previously, national health accounts data compiled by the WHO combines domestic government and external donor funding in their measure of 'government' funding. It was, thus, necessary to collect disaggregated domestic and external funding at country level.

Expenditure data was complemented by qualitative data to establish the extent to which the Abuja Declaration is a feature of national debates and discourses. Relatively complete data were received for Kenya, Malawi, Namibia, South Africa, Uganda, Zambia and Zimbabwe.

The researchers accessed the data from a number of sources as listed in *Table 2*.

Table 2: Sources of data

Country	Data Sources
Kenya	Ministry of Planning and Development, Ministry of Health, Central Bureau of Statistics, National Aids Control Council
Malawi	Ministry of Finance, IMF, National Statistics Office, Ministry of Health, National Health Accounts
Namibia	Bank of Namibia, Ministry of Finance, Ministry of Health and Social Services, National Health Accounts
South Africa	National Treasury, National Health Accounts
Uganda	Ministry of Finance and Economic Planning and Ministry of Health, Uganda Bureau of Statistics, Bank of Uganda
Zambia	Ministry of Finance and National Planning, National Health Accounts, Ministry of Health
Zimbabwe	Ministry of Finance, WHO, National Health Accounts, United Nations General Assembly Special Session (UNGASS), Central Statistics Office

In almost all countries it was not possible to obtain a complete set of data for all the years. This made it difficult to establish trends in expenditure both by government and donors. In some instances, this meant relying on data compiled by international organisations (e.g. WHO). Secondly, almost all the country level researchers found it difficult to access data on disease-specific expenditure, donor expenditure on health and debt relief funds redirected towards the health sector since these data are not delineated in national budgets and expenditure reports. Finally, it was not always possible to obtain much qualitative data on the extent to which the Abuja Declaration is a feature of national debates and discourses.

The quantitative data were inputted to a Microsoft Excel spreadsheet. All expenditure data was reported in the national currency and in nominal terms. The nominal expenditure data was adjusted for inflation and converted into real terms using the consumer price index (CPI), with 2000 as the base year. The CPI for each of the countries was obtained from the United Nations Statistical Division. Once the data was expressed in real terms in the national

currency, it was then converted into US\$ to allow for comparison across the selected countries and over several years.

3. Results

This section presents a brief background on the socio-economic status and health status of each of the countries, before providing a more detailed analysis of each of the country's progress towards the Abuja target.

3.1 Socio-economic and health status indicators

As indicated in *Table 3*, population among the selected countries varies from 2 million in Namibia to 47 million in South Africa (WHO, 2007b). HIV prevalence amongst the Southern African countries (Zimbabwe, Namibia, South Africa, Zambia and Malawi) is about 2-3 times higher than the East African countries (Kenya and Uganda). The level of unmet need for ARV treatment is relatively high in all the countries except Namibia. TB prevalence is high across all countries and ranges from 511.1 (South Africa) to 935.9 (Kenya). Three countries have reported multi-drug resistant tuberculosis (MDR-TB) and Extreme drug-resistant tuberculosis (XDR-TB): Botswana (100 MDR-TB and 2 XDR-TB), Mozambique, and South Africa where XDR-TB is a major epidemic in KwaZulu-Natal Province (SADC Secretariat, 2008).

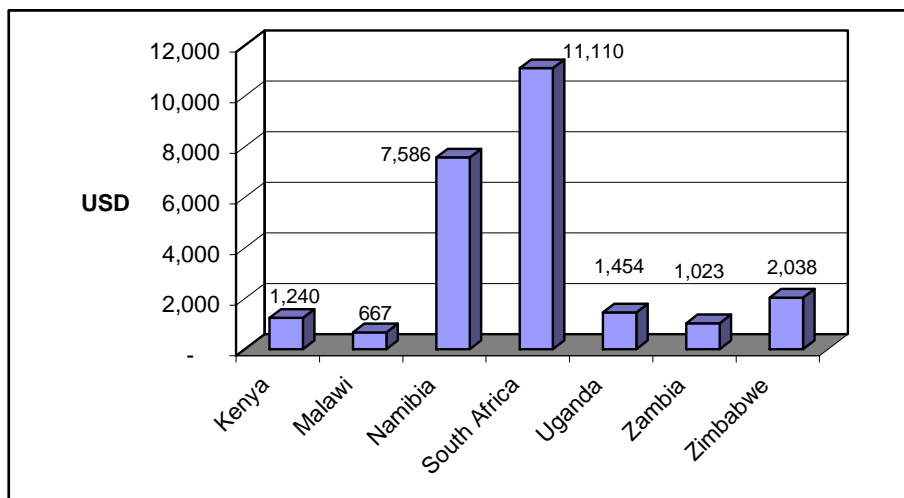
Table 3: Selected population and health indicators, 2005

	Population (in 1000s) total	HIV prevalence in adults aged 15+ years (per 100 000 people)	Prevalence of tuberculosis (per 100 000 population)	% total people in need receiving ARVs
Kenya	34,256,000	6,125	935.9	24
Malawi	12,884,000	12,528	518.3	20
Namibia	2,031,000	17,676	577.5	71
South Africa	47,432,000	16,579	511.1	21
Uganda	28,816,000	6,304	558.9	51
Zambia	11,668,000	15,819	617.8	27
Zimbabwe	13,010,000	19,210	630.7	8

Source: WHO, 2007b

At the outset, it is important to note that the countries vary significantly in levels of economic development as indicated by the GDP per capita. GDP per capita ranges from US\$667 (Malawi) to US\$11,110 (South Africa) (see *Figure 3*). The overall resources available for health potentially vary widely across these countries. With coefficients of inequality in 2003 ranging from 0.43 (Kenya, Uganda) to 0.71 (Namibia), access to these aggregate economic resources is highly unequally distributed, more so in southern than east African countries (UNDP 2005).

Figure 3: GDP per capita (US\$, purchasing-power parities), 2005



Source: World Bank, 2007

At the same time, the disease burden, particularly that arising from the HIV epidemic, in combination with low levels of economic growth is likely to deepen poverty and further constrain economic growth and human development, unless steps are taken to reverse the trend. As *Table 4* indicates all countries except Uganda have experienced falling Human Development Indicators since the 1990s, in large part due to the high burden of disease. This significant decline in HDI puts people in these countries at a significant disadvantage to those from other regions who started at a similar level in the 1970s, such as China, Malaysia and Thailand, but whose populations now have HDIs close to 0.8. Sustained increases in human development over the same period in these latter countries provide an important social base for economic development (EQUINET SC, 2007).

Table 4: Human development index (HDI) trends, 1975-2003

HDI* rank 2004	Country	1975	1980	1985	1990	1995	2000	2004
120	South Africa	0.655	0.674	0.702	0.735	0.742	0.696	0.653
125	Namibia	..	..	..	..	0.693	0.649	0.627
144	Uganda	..	..	0.412	0.409	0.412	0.474	0.508
145	Zimbabwe	0.546	0.574	0.640	0.637	0.589	0.527	0.491
154	Kenya	0.461	0.509	0.530	0.546	0.524	0.499	0.491
165	Malawi	0.320	0.351	0.362	0.371	0.412	0.402	0.400
166	Zambia	0.468	0.475	0.484	0.462	0.424	0.409	0.407

* HDI values were calculated using a consistent methodology and data series. Range is 0 (lowest) to 1 (highest).

Source: UNDP, 2005

The background context for health spending is thus one of high health care demand, with a need for attention to both adequacy and distribution of health spending to prevent the impoverishing effects of ill health.

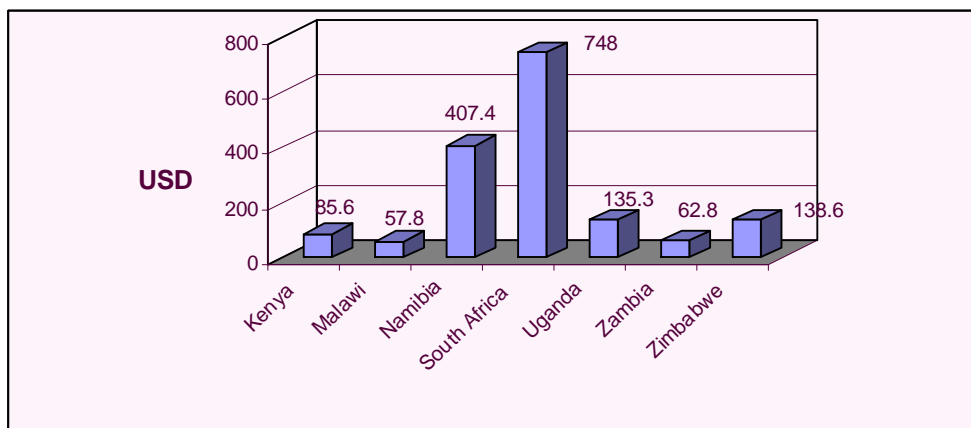
3.2 Health expenditure patterns

This section presents data on health care expenditure trends and where possible attempts to disaggregate it further in terms of domestic government versus external donor sources.

Since it was not always possible to obtain a complete set of data for either all of the countries and/or all of the years, we have excluded country data where there are gaps.

Total health care expenditure per capita ranges from US\$57.8 (Malawi) to US\$748 (South Africa) (see *Figure 4*). Total expenditure on health is the aggregate of general government health expenditure and private health expenditure (i.e. out-of-pocket spending, private health insurance, etc.) and external resources (WHO, 2007c).

Figure 4: Total expenditure on health care per capita at international dollar rate, 2004



Source: WHO, 2007c

While total expenditure on health care per capita is an important indication of the resources being devoted to health services, it is also important to disaggregate this figure in order to identify the funding sources and to be able to determine the relative progressivity of health financing. Progressive funding mechanisms usually include a reliance predominantly on government funding (i.e. from taxes) and pre-payment schemes. On the other hand, a high reliance on out-of-pocket spending tends to be regressive particularly in terms of the burden on low income individuals and households.

There is significant reliance on out-of-pocket expenditure amongst the countries included in this review (WHO, 2007c). When out-of-pocket expenditure is considered as a percentage of total health care expenditure, it varies from as high as 61% and 47% in Uganda and Kenya respectively to 9% and 6% in Malawi and Namibia respectively. This suggests individual households in countries such as Uganda and Kenya with lower levels of economic development and GDP per capita are bearing a disproportionate share of the health financing burden compared to other countries. The level of out-of-pocket spending in Uganda is noteworthy given that user fees at government health care facilities were removed in 2001, indicating that there is still considerable out-of-pocket spending on private health care providers. While this requires further investigation, other research in Uganda within EQUINET, indicates that quality of care problems in public sector facilities are a major reason for use of private sector services on an out-of-pocket basis (Kyomugisha et al, 2008).

With the exception of South Africa, there is significant reliance on external resources to finance health care expenditure across African countries (see *Table 5*). In 2005, in Malawi, external resources contributed over two-thirds of health care expenditure. High income countries can and should commit a share of their GNP to overseas development aid, and a share of this to health. An existing commitment has been made of 0.7% GNP to ODA, and some civil society organisations suggest that 15% of this go to health. Yet unless low and middle income countries also improve their own domestic spending on health, they can become dependent on external funding for core functions, making planning for these

functions unpredictable, due to the short time frames of external funders. However, Ministries of Finance may not see the need to increase their funding of health services while donor funding is high. This is further explored below.

Table 5: External resources for health care as a percentage of total expenditure on health care

Country	2000	2003	2005
Kenya	N/A	25.0	33.9
Malawi	53.6	73.5	71.4
Namibia	6.4	14.1	N/A
South Africa	0.3	0.3	0.5
Uganda	32.4	27.5	35.0
Zambia	N/A	38.0	N/A
Zimbabwe	4.1	13.6	N/A

Source: WHO, 2007c

3.3 Progress towards the Abuja target

Table 6 and Figure 5 indicate the progress of the participating countries towards the Abuja target. It is important to note dramatic differences between the estimates presented below (which only include domestic government funding) and estimates from the WHO national health accounts database (which combines domestic and external donor funding as so-called 'government' funding), cited earlier. For example, while the WHO database estimates that 'government' spending on health in Kenya is over 7% of total 'government' funds in 2003, domestic government funding according to the data in Table 6 is only 6% of total government resources. The disparity between the two sets of estimates is particularly dramatic for countries with substantial donor funding such as Malawi. WHO states that spending on health care was over 25% of 'government' expenditure in 2003, yet when external donor funds are excluded, less than 11% of domestic government funds were devoted to the health sector.

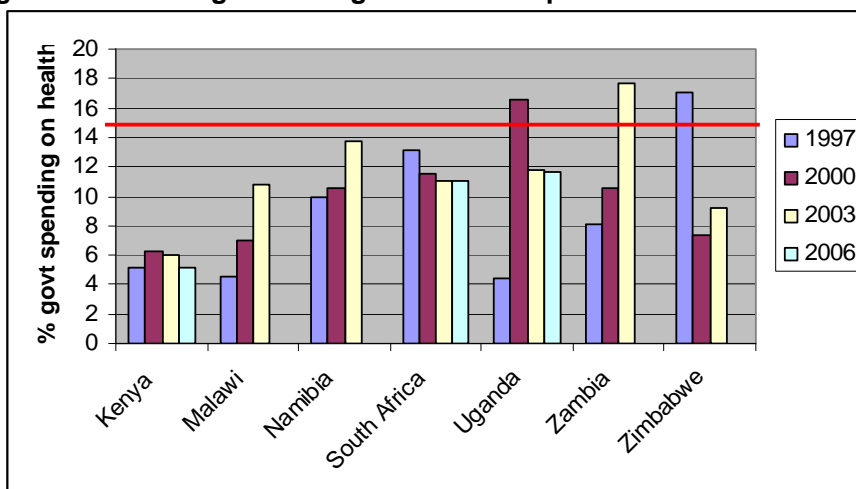
Table 6: Percentage of total government expenditure allocated to health (1997-2006)

Country	1997	2000	2003	2006
Kenya ¹	5.1	6.2	6.0	5.1
Malawi ²	4.5	7.0	10.8	N/A
Namibia ³	10.0	10.6	13.8	N/A
South Africa ⁴	13.1	11.5	11.1	11.0
Uganda ⁵	4.4	16.6	11.8	11.7
Zambia ⁶	8.1	10.5	17.7	N/A
Zimbabwe ⁷	17.0	7.4	9.2	N/A

Sources: 1. Kenyan Ministry of Planning and Development and Ministry of Health; 2. Malawian Ministry of Economic Planning, Ministry of Finance and WHO NHA; 3. Bank of Namibia, Ministry of Finance; 4. South Africa: National Treasury; 5. Uganda: Ministry of Finance and Economic Planning and Ministry of Health; 6. Zambia: Ministry of Finance and National Planning National Health Accounts Reports, MoH; 7. Zimbabwe Ministry of Finance

With the exception of Zambia, all countries are lagging behind the target, although there have been increases in the allocation to health across almost all countries. Kenya is allocating less than 6% of their national budgets to health, while Namibia, Malawi and Uganda are moving closer to the target. It is of concern that Kenya and South Africa are moving away from the target. The economic difficulties in Zimbabwe have undoubtedly contributed to the instability of government spending.

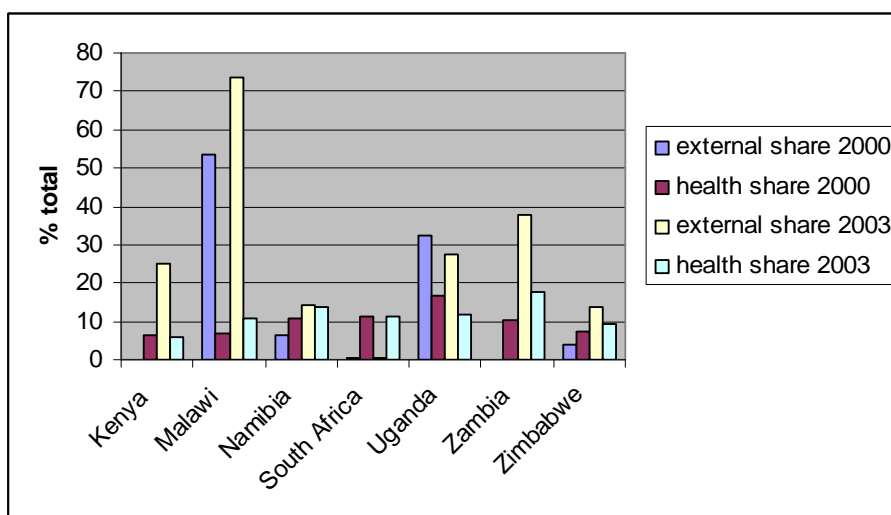
Figure 5: Percentage of total government expenditure allocated to health, 1994-2006



When considering the health sector's share of total government expenditure, but excluding interest payments (i.e. servicing debt), the trend is unchanged although the percentage share is closer to the Abuja target. For example, the health sector's share of non-interest government expenditure was 15% in Namibia in 2003, 12.8% in South Africa in 2006 and 12.5% in Uganda in 2006.

Figure 6 indicates no clear pattern between the share of total health resources that are external and the prioritisation of health in the government budget.

Figure 6: External resources for health as share of total health expenditure and health sector's share of total government expenditure, 2000 and 2003



Source: Tables 4 and 5.

Noting the very different levels of external funding between them, in Malawi, Namibia, Zimbabwe and Uganda, the share of government spending on health and external shares of total health funding were directly related, i.e. they rose or fell together. It does not seem that Ministries of Finance are reducing their spending as external shares increase, nor that falling shares are compensated for by increased domestic funding. The data set this is drawn from is however limited and it would need to be tested over a longer time period.

3.3.1 Debt Relief

As indicated previously, expenditure on health and other social sectors in many African countries, including some of those reviewed in the present report, has been constrained by their heavy debt burden. Malawi, which is amongst the poorest and most highly indebted countries in the world, received a debt reduction package under the Heavily Indebted Poor Countries (HIPC) Initiative supported by the World Bank and International Monetary Fund in 2000. According to the IMF, 32 countries, of which 26 are African, have been approved for debt reduction (IMF, 2007). Uganda and Zambia have also received debt relief. Kenya and Zimbabwe are not eligible for debt relief since their debt burden falls below the threshold of level of indebtedness (IMF, 2003).

A key objective of reducing the debt burden is to free up resources for priority services including health, education and rural development (IMF, 2000). Malawi received about US\$32m and US\$43m in debt relief in 2003 and 2006 respectively, of which 47% was allocated to the health sector (Malawi Ministry of Finance Debt Division, 2007). This is likely to have contributed substantially to the steady progress towards the Abuja target in Malawi, from less than 5% of government spending in the health sector in 1997 to nearly 11% in 2003 (see *Table 6*). Unfortunately, similar data for the other countries was not available.

3.4 Expenditure on HIV/AIDS

A key component of the Abuja Declaration has been a commitment to increasing the allocation towards health services for managing HIV and AIDS. *Table 7* indicates the expenditure patterns by governments and donors for Malawi, Uganda and Kenya.

Table 7: Government and donor spending on HIV/AIDS Services (US\$)

	2000	2003	2006
Malawi¹			
Government spending on HIV and AIDS health services	9,699,120 (50.2%)	6,426,214 (21.9%)	N/A
Donor spending on HIV and AIDS health services	9,635,310 (49.8%)	22,953,419 (78.1%)	N/A
Total donor and government spending on HIV and AIDS health services	19,336,430	29,381,636	N/A
Uganda²			
Government spending on HIV and AIDS health services	N/A	5,992,630 (15.6%)	8,085,669 (4.9%)
Donor spending on HIV and AIDS health services	N/A	32,396,007 (84.4%)	156,310,678 (95.1%)
Total donor and government spending on HIV and AIDS health services	N/A	38,388,637	164,396,347
Kenya³			
Government spending on HIV and AIDS health services	4,899,240 (10.8%)	27,434,940 (40.6%)	97,174,980 (65.8%)
Donor spending on HIV and AIDS health services	40,300,200 (98.2%)	40,124,760 (59.4%)	50,453,820 (34.2%)
Total donor and government spending on HIV and AIDS health services	45,199,440	67,559,700	147,628,800

Sources: 1. Malawi Ministry of Health; 2. Ugandan Ministry of Health; 3. Kenyan National AIDS Council

In Uganda and Kenya, expenditure on health services for HIV and AIDS prevention, treatment and care increased in absolute terms from both domestic and external sources. In contrast in Malawi, government spending on these services declined, while donor funding for these services increased substantially. As indicated in *Table 7*, donor spending on HIV and AIDS health services is substantial across all three countries. It is especially significant in Uganda, where 95% of HIV funding in 2006 arose from donors. The percentage share of total spending on HIV attributable to domestic government funds only increased in Kenya.

On average between 2000 and 2002, OECD countries' total ODA commitments for HIV/AIDS control were US\$2.2 billion per year (UNAIDS and OECD, 2004). The countries receiving the largest share of aid for HIV and AIDS at that time were Zimbabwe (18%), Nigeria (13%), Kenya (11%), South Africa (8%) and Zambia (7%). This situation has possibly since changed, but more recent figures were not available.

Although South Africa receives substantial funding from donors for HIV and AIDS services, government remains the most significant source of HIV funding (Ndlovu, 2005). Of the five billion South African Rand (SAR) allocated to HIV and AIDS programmes in 2006/07, 70% arose from government spending and the remaining 30% was funded by donors (Blecher, 2007). UNAIDS and WHO (2005:16) have noted that: 'South Africa has committed US\$1 billion over the next three years to scaling up antiretroviral treatment, by far the largest budget allocation of any low- or middle-income country'. *Table 8* shows that as the HIV prevalence rates have increased in South Africa, so has government spending on HIV and AIDS. Although government spending on HIV has been increasing very rapidly in recent years, it was starting from a very low base.

Table 8: South Africa: comparison of state spending on HIV and AIDS services versus HIV prevalence rates

Year	99/00	00/01	01/02	02/03	03/04	04/05	05/06
State spending (R000's)	137	234	300	697	1 132	1 655	2 271
Prevalence rates	22.4%	24.5%	24.8%	26.5%	27.9%	29.5%	30.2%

Sources: Schulz-Herzenberg and Reddy, 2007; South African National Treasury; (2007) Barnett and Whiteside, 2006

3.5 Government and public discourse on the Abuja target

To what extent have these shifts in government spending on health been affected by public pressures and advocacy? This question requires detailed policy analysis for a comprehensive assessment, and we report in this section on a single indicator of such public advocacy, that is the extent to which the Abuja target has featured in government and public discourses. We were able to obtain this information from three countries: Malawi, Zimbabwe and Namibia.

In Malawi, during budget negotiations in 2006, the Ministry of Health raised the issue of the Abuja Declaration with the Ministry of Finance and the response from the Secretary to the Treasury was, 'We seem to have too many of these declarations. Health is asking for 15%, Education is asking for 20%, Agriculture, 25%. If we try to fulfil all these commitments we will end up allocating all our resources to a few sectors only – that's unrealistic' (Ministry of Health, 2007). The Malawi Health Equity Network, a civil society organisation has been advocating for increased allocations to health (MHEN, 2006). In the National Assembly, the Malawi Parliamentary Committee on Health is also reported through its chair, Hon. Austin Mtukula, to have drawn on evidence secured via regional interactions and networking to engage in advocacy on the Abuja target in 2007, with further reported improvements in health spending as a share of the total budget (EQUINET, REACH Trust and MHEN, 2007).

In Zimbabwe, although the allocation to health has been fluctuating in recent years, the Abuja target has been highlighted in political discussions. Hon Blessing Chebundo, Chairman, of the Parliamentary Portfolio Committee on Health noted the following to parliament: *'The Government has failed for the past four years to provide funding towards the Ministry of Health to meet the Abuja target of a 15% minimum allocation. Based on the analysis of Vote allocations, the trend is that there is a decline in the allocation'* (Zimbabwe House of Assembly, 2006). Government and civil society have also raised the Abuja target. The Ministry of Health and Child Welfare (2007) has called for the Ministry of Health budget to *'...at least meet the Abuja Declaration target of a minimum of 15% of the Government budget going to Ministry of Health. Our Government is a signatory to the declaration, which was reiterated in Maseru and Maputo in 2003 and 2004 respectively'*. In addition, civil society, through organisations like the Community Working Group on Health have included the Abuja target in their budget submissions and has played an active role in monitoring health care spending (Rusike, 2007).

In Namibia, although the Abuja Declaration has not been mentioned directly, there have been indications that health and increasing health care spending is an important priority which was highlighted by the country's president Hifikepunye Pohamba in two addresses. In the first address to the United Nations General Assembly in 2006 he said *'Our commitment to reduce poverty, to create jobs and to facilitate equitable opportunities for all, remains central to all government activities. To give effect to this commitment, education, health and social welfare are prioritised in public spending.'* More recently, in the state of the nation address in April 2007, he noted *"In light of our historical past, we must persist in our justified institutional bias to support our social sectors, particularly education, health and the plight of the vulnerable groups in society. I have in mind the elderly, the ill, HIV/AIDS orphans and people living with disabilities. It is for these reasons that over the years, the biggest portion of the national budget has been allocated to these sectors."*

Unfortunately, evidence on whether or not the Abuja target is part of public debates in other countries could not be found, suggesting that it has not been actively used for advocacy in these countries.

There has, however, been a growing Africa regional campaign around the Abuja commitment in the 'Africa Public Health Alliance' and the "15 Percent Now!" campaign launched on International Human Rights Day on 10th December 2006. It brings together actors from various sectors of civil society, including from the countries covered in this analysis. A *Communique* supported by 141 African and global organisations and networks on this Campaign included representatives of civil society from all seven countries included in this assessment. The *Communique* followed a Public Health Development and Financing Strategy Development Conference in Abuja, Nigeria 15-18 April 2008, held to mark the anniversary of the 27 April 2001 African Union Abuja Health Declaration. It called for *'African Heads of State and Government to restate their commitment to the Abuja 15% pledge and increasing overall per capita expenditure on health at the next AU Summit and to accelerate its implementation'* (APHA, 2008).

4. Conclusion

The commitment of signatories to the Abuja Declaration can only be assessed by tangible and real increases in budget allocations to the health sector. This review indicates that some seven years after the Declaration, many of the countries are still lagging well behind this target, although there are promising signs of increases in allocations towards the health sector in some countries. There is limited evidence that while external financing accounts for extremely high shares of total health spending in some countries, increased external financing has not been associated with falling shares of government spending on health, and

in fact the opposite has occurred. This does not hold true for AIDS funding, however, where rising external funding has been associated with falling government financing.

There are clear indications that debt relief provides an important opportunity to be able to free up resources and increase spending on health and other social sectors. Increasing revenue from taxation poses a severe challenge for many African countries for various reasons including low levels of income and formal employment in addition to administrative capacity constraints. At the same time, alternate financing mechanisms are being considered across many countries. For instance, prepayment schemes including both community based health insurance schemes and social (or national) health insurance schemes have been introduced in a number of African countries. Although many of these are still in a nascent stage, they hold tremendous potential for increasing resources for health and more importantly, for reducing the burden of direct out-of-pocket payments on households. However, these alternate financing mechanisms alone cannot bridge the health care financing gap. Sustainable universal health care coverage cannot be achieved without substantial government funding for the health sector. Unless governments and the international community fulfil their commitments to achieving the Abuja Declaration, individual households will continue to be faced with an unbearable burden of health care financing.

The challenge to deliver on the Abuja commitment, therefore, remains. Incremental progress towards the commitment in some countries indicates that the shift has begun to take place, and this needs to be safeguarded and sustained. The high level of dependency on external financing, in the absence of reasonable levels of domestic financing, particularly for AIDS, makes health systems vulnerable to unpredictable and unplanned swings. Increased domestic financing in some countries even, in the face of increased external funding is thus welcomed, particularly given substantial absolute shortfalls against adequate per capita spending on health systems.

At the same time, the slow pace of incremental shifts in government allocation towards the health sector demands sustained advocacy and monitoring to translate these shifts into attainment of the Abuja commitment of 15%. The fact that some countries in the region have attained or are very close to this target indicates its feasibility, which combined with the evident need for these levels of spending to secure health systems based on universal coverage, lends support to the reasonableness of the target.

Many countries which are falling far behind this target were not included in this study, as data was difficult to obtain from them. With the regional spread of health problems, including multi-drug resistant disease and cross border epidemic transmission, and commitments such as the SADC protocol on health, ensuring adequacy of health care financing and health systems performance is acknowledged to be a matter of regional concern. This makes monitoring and reporting on these health care financing goals an issue for regional bodies such as SADC and the Health Community of East Central and Southern Africa (ECSA). Indeed the 42nd ECSA Regional Health Ministers conference in its resolutions urged its member states to *'uphold the Abuja Declaration to increase National Health budget to 15% of total government budget and work towards increasing the per capita spending on health according to WHO recommendations'* and to *'develop equitable and comprehensive health care financing structures such as financial risk pooling mechanisms that encompass social health insurance, enhanced public financing and community health financing'* (ECSA RHMC, 2006).

Monitoring the Abuja commitment calls for a consistent body of evidence relevant to its terms, separating government and external funding and covering relevant information on debt servicing levels, accessible and reported nationally, compiled regionally and internationally and used to encourage, reinforce and assess the impact of progress. Yet as

evident from this study, this body of evidence is not immediately accessible; global data sources at WHO do not compile evidence in a manner that enables monitoring of domestic spending, and national data is not easily accessible. Part of the campaign for the commitment should include ensuring access to consistent, quality and timely data on health care spending.

Of course, it is not simply the adequacy of health care funding that is important, but also its fairness. As further explored in other EQUINET studies and reports, if health systems are to be *national* (nationally determined and managed), *comprehensive* (with adequate financing across all priority health needs), *universal* (covering and accessible to all) and *people centred* (empowering, ensuring inclusion and not raising barriers to health care), then resource mobilisation needs to:

- be fairly obtained, i.e. to a greater extent from those with greater wealth;
- avoid impoverishing health care spending by poor people; and
- allocate resources towards areas of highest health need and greatest health impact (McIntyre et al, 2005; EQUINET SC, 2007).

There is a mounting Africa-wide campaign for the 'Abuja 15%', and the "Abuja plus" position that EQUINET has adopted resonates with existing campaigns to cancel debt and to meeting commitments to 0.7% of GDP to be devoted to ODA by high income countries. While some countries have translated this into a common articulation of the commitment to 15% government spending on health across Ministries of Health, parliament and civil society, this is not the case across all countries, and the Ministries of Finance are conspicuously silent, or in some cases discouraging, on the issue. While an AU Ministers of Finance and Planning and Economic Development meeting held in Addis Ababa, Ethiopia from 26th March to 2nd April 2008 noted with concern the necessity for long-term sustainable financing of and investment in health created by AIDS and other diseases, the Finance Ministers were publicly silent on the Abuja commitment and there are unconfirmed reports from people attending the meeting that some Ministers of Finance argued for the Abuja target adopted by their heads of state in 2001 to be abandoned.

Ministries of Finance are generally opposed to any efforts to limit their flexibility in allocating resources between sectors (Jones and Duncan, 1995). Such opposition will be even greater when several sectors are simultaneously attempting to establish explicit target shares of government funds, as was illustrated earlier in the debates on Malawi. While there needs to be an element of inter-sectoral resource allocation flexibility to respond to changing government priorities over time, these decisions are not the sole preserve of Ministries of Finance, and are a matter for public and parliamentary debate, and for input from other sectors. Such debate has to explicitly recognise that government spending on a range of social sectors outside the health sector (such as education and social welfare) have positive health benefits. Pursuit of the Abuja target should not be seen as potentially jeopardising government spending on other social sectors. Instead, the emphasis should be on seeking to expand government spending on social sectors overall, and within that, for the health sector to receive a fair share of social spending.

Parliamentarians, civil society groups and health sectors have an important role to play in generating public debate on inter-sectoral priorities and in advocating around the Abuja commitment. Such advocacy is underpinned by the fact this it was African Heads of State, as opposed to simply health sector representatives, who committed themselves to this target. The evidence of health need is clear, and the costs of not achieving adequate health spending to deliver accessible health care has been articulated, whether in relation to unmet health needs, new disease epidemics, grave and rising public health threats, and their particular risk for vulnerable and disadvantaged groups in society (SADC Secretariat, 2008; EQUINET SC, 2007; AU, 2007).

Clearly increasing health spending is in part a response to recognition of socially unacceptable deficits in the right to health, and is fuelled by social demand. The demand for 15% of government resources to be devoted to the health sector is not unrealistic in the context of spending levels in countries with strong health systems.

The concerns of finance ministers must also be confronted head-on. A convincing case should be presented on the urgent need to strengthen health systems in African countries through increased government funding, not as a *cost* to the economy, but as a *benefit*. Towards this, perhaps greater advocacy can be directed to the positive impacts experienced by countries that are increasing their government spending on health care and meeting the Abuja commitment. This can be observed in the impact on the necessary public and health sector leadership to lever other contributions to health, on protection against impoverishment and inequality resulting from unaffordable levels of household spending on health care in the lowest income households and on building universal health care coverage.

There is a case for advocacy to highlight that those low- and middle-income countries that have achieved universal health care coverage highlighted earlier in this report, have also demonstrated a major and consistent commitment to prioritising social sectors in government funding and have performed better in equitable economic development (i.e. economic growth with improved income distribution patterns).

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Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in the region:

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- Health rights as a driving force for health equity
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