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Meeting the promise: Progress on the Abuja commitment of 15% government funds to health

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Key messages:

- Devoting **15% of domestic public funds to the health sector is necessary** - both to address the health and health care needs within east and southern Africa (ESA) and to ensure progress towards building a universal and comprehensive health system
- The target of **15% is not unrealistic** – it is very much in line with levels of public spending in other countries around the world
- Achieving the 15% target demands that public funds not be consumed by debt servicing, so rapid implementation of **debt cancellation is critical**
- The 15% is understood to mean *domestic* public spending on health, *excluding* external funding. It should be **regularly monitored and publicly reported** by governments
- Even if countries achieve the 15% target, for many there will still be a substantial gap in funding for health services. More resources flow out of Africa than into the continent, so sustainable health financing demands global solidarity. **OECD countries should meet their commitment to contribute 0.7% of their GNP** as official development assistance (ODA).
- Increased **spending on health services should not be at the expense of spending on other social services**.

What is the Abuja target?

In 2001, in Abuja Nigeria, Heads of States of the African Union (AU) member states committed to allocating at least 15% of annual government budgets to their health sectors. At the same time they called upon donor countries to complement their efforts to mobilise resources domestically by fulfilling their commitment to devoting 0.7% of their GNP as ODA to developing countries and cancelling Africa's external debt in favour of increased investment in the social sector.

The Abuja target, thus, consists of three components; African countries should:

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

Why the target?

There is a massive mismatch between the health care needs of African countries and the resources available to meet these needs. African countries account for 10% of the world's population, but have 25% of the global disease burden, 60% of the people living with HIV, and the highest burden of TB and malaria globally. Yet, Africa accounts for less than 1% of global health spending and contains only 2% of the global health workforce. The World Health Organisation (WHO) estimated in 2001 that US$80 per person per year was required for a comprehensive health system including a minimally adequate set of interventions and the infrastructure to deliver them. Very few ESA countries have health care spending levels anywhere near this amount, so there are major unmet health needs.

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The effort to close the health care need – resource gap requires committed action on three fronts:

Firstly, African governments themselves must demonstrate their commitment to health services by devoting an increasing share of their *own* resources to the health sector. Nobel Peace Prize Winner Archbishop Desmond Tutu stated in 2008: *"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."*

Secondly, government efforts to increase domestic funding of health services should not be jeopardised by unviable debt burdens. Over the past three decades, ESA countries paid an average US$14 per capita annually in debt servicing, in many countries more than their average spending on health. Cancelling debt makes it more feasible for African governments to reprioritise their scarce tax funds towards health and other social services.

Thirdly, even if African countries spend 15% of domestic public funding on health, for many this still leaves a substantial funding gap to achieve a minimally adequate comprehensive set of health services. It is important to track the health sector's share in overall Gross domestic Product (GDP) and how much of the GDP is in government revenue, or the Abuja target may remain as 15% of low or diminishing levels of government resources. Equally, raising domestic resources for this is limited by the significant net outflow of resources from Africa. Reverse flows through overseas development aid (ODA) are required to close this gap and OECD countries should meet the commitment they made to contribute 0.7% of their GNP as ODA.

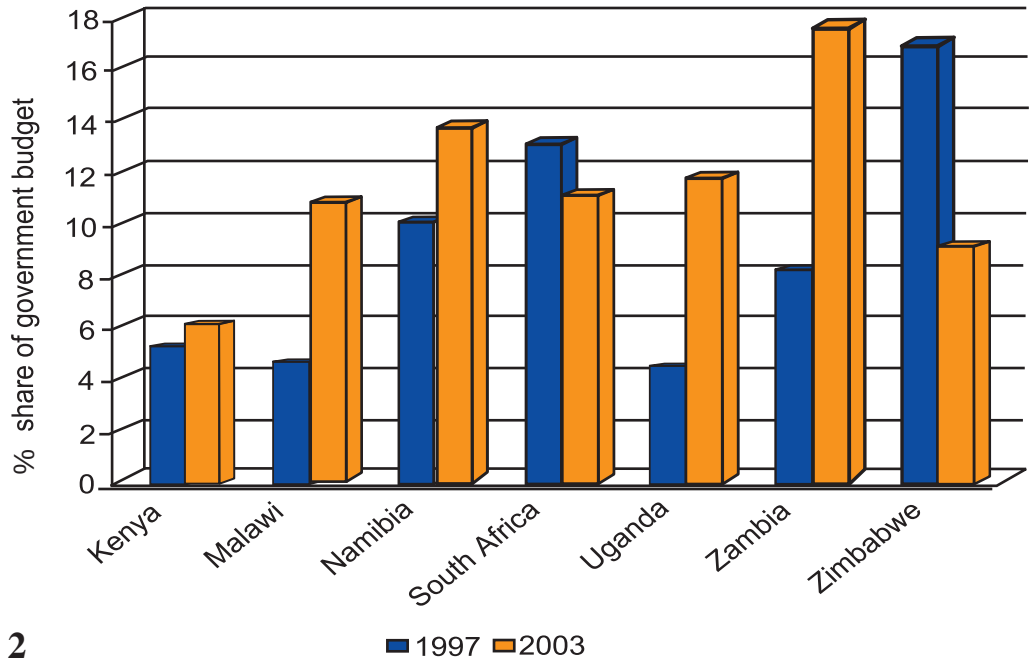
Has there been any progress towards the target?

15% of government budgets for health

Given that the major source of routine data on country level health care expenditure, the WHO's National Health Accounts database, combines domestic tax funding and donor funds in their category of 'government expenditure', EQUINET commissioned researchers in some ESA countries to compile data on government's own spending before and after the Abuja commitment. The figure below shows the data.

Several countries (Malawi, Namibia, Zambia, Uganda) have made considerable progress in increasing domestic funding

Percentage share of government expenditure allocated to health (1997 & 2003)



Progress towards the Abuja target in Malawi

Malawi's efforts to move towards the Abuja target deserve specific mention. Despite having the lowest level of national income of the seven ESA countries reviewed here, there has been remarkable progress in increasing the allocation of government funds to the health sector, from a mere 4.5% in 1997 to 7% in 2000 and 10.8% in 2003. The impact of debt relief on freeing up limited government funds for social services is well illustrated in Malawi. Malawi received approximately US$ 32m and US$ 43m in debt relief in 2003 and 2006 respectively under the Heavily Indebted Poor Countries (HIPC) Initiative, nearly half of which was allocated to the health sector.

Another key factor driving progress towards the Abuja target in Malawi is the active advocacy for it by civil society and parliamentarians. The Malawi Health Equity Network, a civil society network, has been advocating for increased allocations to health, as has the National Assembly, through the Malawi Parliamentary Committee on Health. After advocacy for the Abuja target in the 2007 budget debate, health spending as a share of the total budget increased further.

towards the Abuja target, shortly after the commitment was made. This shows that the target *can* be met, using domestic resources. Kenya has made less progress, and government allocations to the health sector have declined in South Africa and Zimbabwe.

Debt cancellation

African countries spend more on debt than on health. At levels of US$6.2 billion by 2000, repayments reached about four times the original 1980 debt by 2002. This significantly reduces the discretionary public funds available, including for health. Pressure from states and civil society globally triggered a series of debt relief measures, first under the HIPC initiative and then the 2005 G8 Summit proposal to cancel 100% of outstanding multilateral debts of eligible countries, with 26 African countries approved for debt reduction. Experience from the first round of the initiative suggests that while the debt stock has fallen and social spending increased, there has been less benefit to the health sector and rising interest rates have kept debt service obligations high, limiting social spending. The call to cancel all debt servicing obligations still remains urgent.

ODA of 0.7% of GNP

Excluding debt relief for Nigeria, real levels of aid to sub-Saharan Africa rose by only 2% in 2006. Average contributions of 0.3% of GNP to ODA from OECD countries remain well below the UN-agreed target of 0.7% of GNP. In 2006 only Sweden, Luxembourg, Norway, the Netherlands and Denmark met this commitment. Thus, it is not only some African governments that are failing to meet their commitments to increased domestic funding of health care. High income countries are, with some exceptions, also not meeting their agreed aid targets.

What needs to be done to meet the target?

Measure and monitor progress: Tracking progress toward the Abuja target calls for accurate regularly available data on government health care expenditure from domestic funding sources. National Health Accounts (NHA) data should separate out domestic and donor funding. This means amending the WHO database to show this, as recommended in its own manual on how to conduct a NHA at country level. Data should be routinely compiled on funding to health as a share of domestic spending, and of GDP, on the level of spending on debt and debt servicing, and on the share of external funding in the health sector.

Regularly publicly report on progress: The data should be made publicly available, particularly as part of budget debates and monitoring. It should also be reported in the annual regional meetings of ministers of health and of finance in the East Central and Southern African Health Community, in the Southern African Development Community (SADC), East African Community (EAC) and to the AU heads of state.

Advocate on gaps and gains: Vigorous national and regional advocacy around the 15% target can add further local evidence:

- On the extent of health needs within the country, the nature of the interventions required to address these health needs and the magnitude of the financial and other resources required to provide these services.
- Of the gains in improved health care outcomes from periods of improved domestic funding, including in promoting equitable resource allocation and increased funding to primary and district levels.

Point to examples from existing practice: The 15% target is realistic given that some African countries have reached this target. Further, most high income countries and many low- and middle-income countries devote more than 15% of government funds to health care (e.g. 21% in Colombia, Costa Rica and El Salvador; 19% in Australia, Guatemala, Switzerland and the USA; etc.).

Make clear the need for an increase in all social spending: A range of other publicly-provided social services (e.g. education, social welfare, water provision) also have positive health benefits. Allocating 15% of government budgets to health services should not be at the expense of these other social services. Increased public spending on social services is fundamental to states meeting their obligations to promote human development.

Build alliances internationally: Debt cancellation and ODA are vital for increased funding of health services. Macroeconomic frameworks, including expenditure limits, can limit absorption into the budget of significant new external resources available. These issues call for advocacy not just at national level, but also at international level.

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 advocacy and action needs to ensure that the the full scope of the 2001 Abuja commitment is met:

- 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*).

Further resources

Atim C (2006) *Financial Factors Affecting Slow Progress in Reaching Agreed Targets on HIV/AIDS, TB and Malaria in Africa*. DFID Health Resource Centre Prepared for the African Union: Addis Ababa, available at www.africa-union.org, downloaded on March 7, 2006

EQUINET Steering Committee (2007) *Reclaiming The Resources For Health: A Regional Analysis Of Equity In Health In East And Southern Africa.* EQUINET: Weaver press, Fountain Publishers and Jacana media Harare, Uganda and Johannesburg.

Govender V, McIntyre D, Loewenson R (2008). *Progress towards the Abuja Target for government spending on health care in East and Southern Africa.* Health Economics Unit, University of Cape Town and EQUINET; Cape Town and Harare.

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