

# How to (or not to) . . . measure performance against the Abuja target for public health expenditure

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In 2001, African heads of state committed ‘to set a target of allocating at least 15% of our annual budget to the improvement of the health sector’. This target has since been used as a benchmark to hold governments accountable. However, it was never followed by a set of guidelines as to how it should be measured in practice. This article sets out some of the areas of ambiguity and argues for an interpretation which focuses on actual expenditure, rather than budgets (which are theoretical), and which captures areas of spending that are subject to government discretion. These are largely domestic sources, but include budget support, which is externally derived but subject to Ministry of Finance sectoral allocation. Theoretical and practical arguments in favour of this recommendation are recommended using a case study from Sierra Leone. It is recommended that all discretionary spending by government is included in the numerator and denominator when calculating performance against the target, including spending by all ministries on health, social health insurance payments, debt relief funds and budget support. Conversely, all forms of private payment and earmarked aid should be excluded. The authors argue that the target, while an important vehicle for tracking political commitment to the sector, should be assessed intelligently by governments, which have legitimate wider public finance objectives of maximizing overall social returns, and should be complemented by a wider range of indicators, to avoid distortions.

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## KEY MESSAGES

- Although it is essentially a political commitment, the Abuja target, which commits African governments to spending 15% or more of their public expenditure on health care, remains one of the few international benchmarks for health financing. It is therefore important that it is interpreted consistently. There are currently no guidelines for how to measure it.
- This article develops an interpretation of the target which focuses on the ‘spirit’ of Abuja—increasing the resources which government allocates to the health sector.
- Based on this, it is recommended that all discretionary spending by government is included in the numerator and denominator when calculating performance against the target, including spending by all ministries on health, social health insurance payments, debt relief funds and budget support. These are all subject to government discretionary allocation. Conversely, all forms of private payment and earmarked aid should be excluded.
- The authors argue that the target, while an important vehicle for tracking political commitment to the sector, should be assessed intelligently and within a wider range of indicators, to avoid distortions.

## Introduction

In 2001, African heads of state committed to the following pledge: 'to set a target of allocating at least 15% of our annual budget to the improvement of the health sector' (Organisation of African Unity 2001). The pledge was made in the context of meeting the challenges of communicable diseases, but the target has taken on a life of its own since, being used to assess the extent to which governments are meeting their commitment to the health sector (WHO 2011).

It is not clear how 15% was chosen, and it is hard to justify the figure itself. Health expenditure levels should reflect local health needs, utilization and costs, and so there is no one optimal amount for countries to spend on health care. While there is a sense to calculating minimum spend per person to provide essential health care packages, as done by the Commission for Macroeconomics and Health (World Health Organization 2001), the logic of suggesting a targeted proportion of spending is less clear since this will produce very different amounts, depending on the overall public expenditure levels. Moreover, a percentage as such tells us nothing about how the funds are used, or what benefits they generate (HRC 2006). From a general public finance perspective, government should be free to allocate resources to whichever investments maximize returns for the society. There is therefore some ambivalence about the use of sector-specific allocation targets, which may also divert attention from other important goals, such as growing the domestic revenue and tax base.

Nonetheless, such a target may encourage a government to strengthen its general commitment to the sector. Although there were other factors at play over the period, in the 10 years since Abuja, 27 African countries increased the proportion of total government expenditures allocated to health, while 7 countries reduced their relative contributions of government expenditures to health and in the other 12 countries, there was no obvious trend upwards or downwards (WHO 2011). There is also logic in focusing on public commitment to health rather than, say, focusing on the proportion of Gross Domestic Product (GDP) spent on health given the international evidence that pooled public funding for health care has a significant impact on health status in a way that private funding, even through insurance, does not (Moreno-Serra and Smith 2012). Moreover, there are very few clear targets in the health financing field, and perhaps because of this, the Abuja target is being widely used as a benchmark, bringing political pressure to bear on governments, especially by civil society and advocacy groups (ActionAid 2005; Govenda *et al.* 2008). This being the case, it is important that it is used consistently, and measured in ways which allow for fair comparisons across countries and over time. Yet to our knowledge, concrete guidance has never been developed on how to measure it. This article lays out some of the areas of uncertainty surrounding how to measure performance against the Abuja target and suggests a concrete formulation that can be used consistently across countries. The case study of Sierra Leone is used to give an example of some of the practical issues.

The issues raised in this article have relevance beyond the African countries that have signed up to the Abuja declaration. Sector-wide approaches have often used the proportion of government spending on health for monitoring performance but the indicator itself is often ill-defined.

## Measuring Abuja in practice—definitions and issues

A number of issues are apparent in deciding how to assess whether the target has been met.

### Budgets vs expenditure

The original pledge was stated as a proportion of national budgets that may not be realized in practice. Budgets are normative, but if the resources are lacking or if priorities change mid-year, there may be major discrepancies between what is budgeted and what is spent. As the aim was to provide adequate funding for health care, the focus should presumably be on actual expenditure, rather than budgets, and indeed most analyses of performance against the Abuja target do analyse expenditure in practice (Govenda *et al.* 2008; WHO 2011).

### Domestic sources vs domestically managed funds

A second question is whether the Abuja target should include just domestically raised resources, or should also include funds that are managed by the government but may have originated externally, such as sector-wide support, budget support or other aid flows which pass through public expenditure channels. Some of these are on-budget (included within budget plans), while others are not, coming in during the year but still disbursed and accounted for by the Ministry of Health or its agencies.

Past analysis has not been consistent on this (WHO 2011). As the focus of the target was to ensure sufficient domestic commitment and priority to the sector (it was complemented by a re-statement of the goal of 0.7% of Gross National Income (GNI) to be devoted to aid by the Organisation for Economic Cooperation and Development (OECD) countries), we acknowledge that in principle the Abuja target should include only domestically raised resources. However, if the spirit of the indicator is to increase resources allocated to health by government, then all resources for which the Ministry of Finance has discretion over their allocation need to be counted—including those of external origin. Whether money is domestically or externally raised, it says the same thing about a government if it chooses to allocate it to health.

### Budget support—in or out?

An example of external funds over which the Ministry of Finance has discretion is budget support, which is funding from donors not allocated to any particular sector. It is therefore part of government discretionary funds, and as such, we argue, qualifies to be included in the numerator and denominator, even though it is external in origin. This fits with the spirit of Abuja—increasing government commitment to the sector—and also resolves practical difficulties associated with tracking funds which have gone into a shared pot (see Sierra Leone case study).

A second consideration on this matter is that excluding budget support from the calculation may allow for creative accountancy, such that the Abuja target is achieved so long as there is enough budget support. For example, governments could allocate all their budget support to sectors without Abuja-like targets, reallocating the domestic resources from those sectors towards health. In this way, governments could appear to meet the Abuja target without actually making any material change to the health sector. This

would only not be possible if budget support was not large enough to cover reallocation from other sectors. As such, the Abuja indicator becomes a measure of relative size of total budget support rather than of domestic allocation to health.

Finally, assuming that Ministry of Finance funds are fungible, including or not including budget support actually makes no difference to the final ratio: the ratios of budget support to domestic revenue will be the same in the budgets of the individual ministries as they are in the Ministries of Finance. It follows that the ratio of government expenditure on health to total government expenditure will be the same with or without budget support (so long as the numerator and denominator either both do or both do not include budget support).

### Non-discretionary spending

On the other hand, money spent by the government, but not at its discretion should be treated differently. Non-discretionary expenditures include interest payments on the national debt and payments for entitlement programmes and also external funds that are earmarked for specific uses (OECD *et al.* 2011). Even when such funding is incorporated into a sector strategy, through a Sector-wide approach (SWAp), for example, the funding is still outside the control of the Ministry of Finance and so does not signal a commitment by government to the health sector. Indeed there is a danger that if the funding is included in meeting the target domestic governments may reduce domestic spending on health. We acknowledge, however, that there may be problems in excluding such resources immediately (see discussion).

### Matching denominator to numerator

However it is concluded that the indicator be interpreted, it is important that anything included in the interpretation of government expenditure on health (the numerator) is also appropriately included in the interpretation of total government expenditure (the denominator) and vice versa. For example, if budget support allocated to health is to be included in the numerator, then total budget support allocated across all sectors should be included in the denominator. The same is true of items deemed non-discretionary (such as earmarked aid or sector-specific support), which should be excluded from both the numerator and denominator.

### Capital and recurrent expenditure?

Budgets in some countries are divided into development and revenue or regular budgets, with the former including both capital spending and project-level spending that has not yet been absorbed into regular spending. Similarly, many countries have separate capital and recurrent budgets. As development and capital funds are part of the government commitment to the sector, these should logically be included in the numerator and denominator.

### User fees

In some countries—Ghana, for example—the revenues that facilities raise from user fees are included in the annual budgets. This allows for a more comprehensive assessment and planning of the public resource envelope. However, these fees, while

forming revenue for government, are private expenditures, and so are excluded for the purposes of the Abuja target. They also breach the principle of discretionary funding—they are not funds that could have been allocated to another sector as they are paid directly to and retained by health facilities. They should therefore not be included in either denominator or numerator.

Where fees are not retained but are passed up the system to general public coffers—for example, in Sudan, where fees in health facilities are commonly collected and retained by the Ministry of Finance—they have joined the government discretionary funding pool, for management purposes, but as they are direct private health payments in origin, they should still not be included in the denominator or numerator. It is acknowledged, however, that separating these out from other streams may be challenging in practice.

### Debt forgiveness

Funds from the Highly Indebted Poor Country initiative, for example—are another difficult category. These are domestic funds that should have been paid in debt repayments but have been ‘forgiven’ on condition that they are used for specified priority purposes, such as poverty relief. They are therefore not fully discretionary but are nevertheless domestic in origin and subject to government inter-sectoral allocation, and therefore should be included, we argue, with the Abuja expenditures. There is evidence that in some countries, such as Malawi, these have contributed substantially to increases in public resources for the sector (Govenda *et al.* 2008).

### Health insurance

Health insurance payments are also a debateable area. If the contributions are voluntarily made by employers and/or employees, then logically they should not be included in the Abuja calculations. In the social health insurance schemes which are growing in a number of countries, such as Ghana, Tanzania and Kenya, contributions are mandated by government and rely on public levies for substantial proportions of their funding, covering vulnerable and other groups (Witter and Garshong 2009). Funding for the schemes is also taken into account by the Ministry of Finance when planning discretionary spending. We suggest including both schemes that are part-financed by government and schemes that are mandated by government and so are part of the public policy, even if substantially financed by individuals and employers. Voluntary and private schemes established by employers separate from public policy would be excluded.

### Spending by other ministries

An added complexity is that mandatory health insurance may be managed by other ministries. This is also true of other spending where ministries from defence to education may allocate resources to promoting health. National health accounts (NHA) guidelines suggest that spending should be included as health spending if the primary purpose of spending is to promote health (so military hospitals are included but spending on water supplies are not). Thus in principle, health expenditure by other ministries should be eligible for inclusion in the Abuja target. It is not always easy to gather information from other

ministries or, in decentralized systems, spending by local government, but international partners are now supporting the institutionalization of national accounting, allowing for annual tracking of expenditure on health by all ministries.

## Case study: Sierra Leone

### The context

For the past two decades, Sierra Leone has consistently ranked in the bottom 10 of the United Nations Human Development Index: it is currently ranked at 177 of 186 countries (HDI 2012). The demographic health survey in 2008 estimated that the infant mortality rate was 89/1000 live births, that the under-five mortality rate was 140/1000 live births and that the maternal mortality rate was 857/100 000 births (Government of Sierra Leone, Statistics Sierra Leone 2008). In response to these findings, the Ministry of Health and Sanitation (MoHS) recently introduced a number of major policies to improve the health status of vulnerable groups. The most notable have been a free health care initiative for pregnant and lactating mothers and children under five; pay reform for public health sector employees and a performance-based financing mechanism focusing on maternal and child health indicators for public providers of primary care. In addition to this, many donors, non-governmental organizations (NGOs) and faith-based organizations (FBOs) have flocked to the sector. In 2010, 25% of total health expenditure (THE) was coming from donors, with 7% coming from the Ministry of Finance and Economic Development (MoFED) and the rest from private sources (including households). Over the same period the role of NGOs/FBOs and donors as agents in financial transactions rose to more than 16% of THE (Government of Sierra Leone *et al.* 2012).

### The role of the Abuja target

The combination of the rollout of large government policies and a major inflow of donor and NGO/FBO activity and expenditure has meant both that THE has grown rapidly and that the composition of where this money is coming from has changed. In the longer term, it is important that the foreign investment into the health sector does not crowd out the domestic investment that is so important to its sustainability. The MoHS aims to put continued pressure on MoFED to increase its allocation of the budget, and this is cemented in one of the sector's central documents: the National Health Sector Strategic Plan (MoHS 2009). The document includes the objective to ensure at least 15% of national budgets are allocated to health. The MoHS aims to calculate the Abuja indicator on a yearly basis as part of its NHA, and present it to MoFED. It is also hoped that MoFED can present it to donors as evidence that they are directing their resources towards poverty reduction strategies.

### Measuring the target

The first attempt to calculate the indicator took total MoFED expenditure on health as the numerator, and total domestic revenue as the denominator. This produced a percentage of 13%. However, this raised concern within the MoHS, as it

seemed too high. On a closer look it became apparent that total MoFED expenditure on health was calculated by summing MoFED expenditure on health personnel; non-salary, non-interest recurrent expenditure on health; transfers to local councils for provision of health services and domestic development expenditure on health. This included money originally coming from grants and loans, which in turn included budget support. Domestic revenue, however, did not include money from grants and loans—thus the ratio had been inflated through inclusion of a category of funds in the numerator and not the denominator.

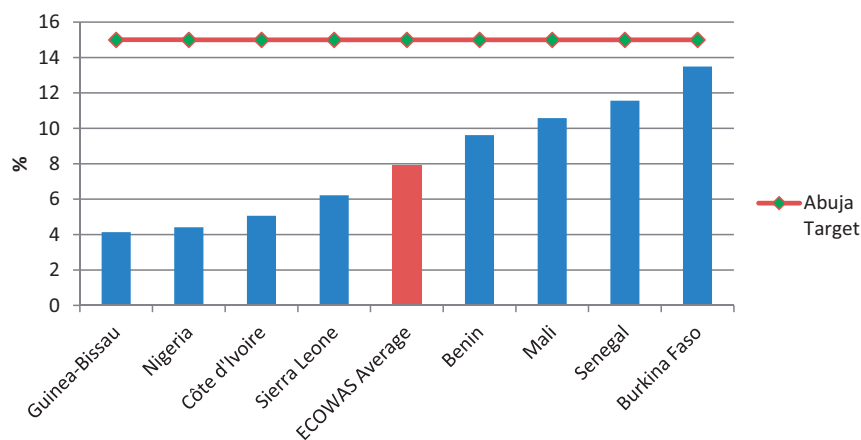
An attempt was then made to calculate MoFED expenditure on health sourced only from domestic revenue. However, it was found that this data were not kept by the current accounting methods. Most funds are not tracked through MoFED—rather they are all put into one pot, mixed together and then dispersed (they are fungible). Following this, it was argued that inclusion of non-sector-specific grants and loans should not make any difference to the calculation. The ratio of grants and loans to domestic revenue would be the same in MoHS's budget as it was in MoFED's. It follows that the ratio of MoFED expenditure on MoHS to total MoFED expenditure is the same with or without grants and loans (so long as the numerator and denominator both either include or do not include them). Hence, it was ultimately calculated as total MoFED expenditure on MoHS as a percentage of general government total expenditure. Here, both numerator and denominator included money sourced from budget support, and the proportion came out as 6.22%.

### Interpreting and using the results

Once calculated, to maximize its policy effect it is important to put it in a relevant context. For the Sierra Leonean MoHS this is often done through comparison with the Economic Community of West African States (ECOWAS). The most widely respected source of this information within the Ministry is generally the World Health Organization's data repository. However, finding definitions of the indicators reported on in this repository, or adequate links to sources of the information, is often difficult. Nonetheless, the indicator 'general government expenditure on health as a percentage of total government expenditure' was considered adequate (see Figure 1).

We can conclude from regional analysis that the pledge made in Nigeria in 2001 to allocate 15% of domestic resources to the promotion of health is proving a challenge across much of ECOWAS. However, Sierra Leone is allocating less than most and is in the bottom half of the region. Even to achieve the regional average Sierra Leone would have to increase the proportion of MoFED's budget allocated to MoHS by around 30%. To get a better understanding of Sierra Leone's progress towards the target it would be necessary to look at time series data, as from this alone it is not clear if the country is moving towards or away from it. However, it is not clear if previous estimates have been calculated using the same methodology as that used for the NHA 2012, jeopardizing the validity of such analysis. Indeed, this criticism also applies to the comparative analysis as it is





**Figure 1** Government expenditure on health as % of general government expenditure (selected West African countries), compared to Abuja target. *Source:* WHO data repository, 20/9/2012 and Sierra Leone NHA 2012.

not clear that all countries have used a common calculation to get their own indicators, or that Sierra Leone has appropriately interpreted the Abuja target at all—which is the reason it is important to clarify how this indicator is to be calculated, both across time and countries.

## Recommendations

If the Abuja target is used to compare government commitments to health over time and across countries, it is important that it is interpreted consistently and easily. Based on the issues raised above, we make the following recommendation. This is based on the understanding that the purpose of the Abuja target was to secure greater government financial commitment to funding public health care, and that it should therefore only include funds over which government has inter-sectoral allocation discretion. This interpretation is consistent with the approach currently taken to analysing health expenditures by WHO (World Health Organization 2012).

The target should include in both numerator and denominator (NHA classifications in parentheses) (OECD *et al.* 2011):

- Transfers from government domestic revenue (FS.1) including:
  - Revenue and capital expenditure through the Ministry of Health.
  - Spending on health through other key ministries, such as local government and education.
  - Debt relief funding channelled into health.
- Social insurance contributions from employees, employers and self-employed as they are part of an overall coverage plan/health policy and include funding from general taxation (FS.3). This would also include mandated pre-payment plans (FS.4).
- Budget support—these are classified by NHA as ‘non-earmarked foreign revenues’ and form part of FS.2.

Both the numerator and denominator should exclude:

- Sector-wide support (part of FS.2) and direct external aid to the health sector (FS.7).

- Private spending for health—which includes out-of-pocket payments made directly to various providers (FS.6), private prepaid plans (FS.5), including payments to community financing schemes and other private insurance plans, and indirect payments for health services by employers (firms) and local charitable groups.

Monitoring of the commitments can be undertaken using the NHA classification which largely allows for a straightforward grouping of ‘Abuja’ spending. The exception is international funding that is classified under one code (FS.2) but would need to be split into financial revenues earmarked for health and non-earmarked foreign revenue (budget support).

## Setting Abuja in the wider development context

Reaching the Abuja target will be challenging—the global median expenditure of governments on health as a proportion of total government expenditure was 11.4% in 2009 (World Health Organization 2012). The WHO Africa region as a whole averaged just under 10%, with only the Americas and the higher income countries spending more than 15%.

The Abuja target, if clearly defined and operationalized, can provide a straightforward benchmark to measure government commitment to the health sector. However, the target may be misleading if used unthinkingly. It could, for example, have the perverse result of encouraging a government which already has a health sector well funded by international partners to divert domestic resources from other priority sectors that do not have access to international resources. As with any sector objectives, targets need to be set as part of any overall framework for assessing how best to utilize public money to achieve overall development goals. A danger with an Abuja-like target is that governments are asked to increase spending on a sector regardless of the impact on other important government priorities. If an increase in health spending is delivered as part of a ‘peace dividend’ through reduced spending on defence then this may be considered reasonable. If the spending can

only be increased by reducing on other essential sectors such as secondary schooling or roads, then the rapid target achievement could be detrimental to overall development. Arguably, Abuja-type commitments should be set in the context of an overall national development plan that focuses on how to improve public services and build human capital. Other sectors might also benefit from a similar kind of expenditure tracking as developed for health at Abuja.

Simple targets, such as the Abuja declaration, can help to boost domestic commitment but will require careful allocation and monitoring to realize benefits and avoid unintended consequences. One question to ask in monitoring how a country is managing to achieve its target is who is benefiting and losing from the spending. One way to boost spending, for example, would be to mandate formal sector employers to begin or increase formal sector contributions to insurance schemes. While this may indeed increase the overall level of risk pooling, it will arguably have little impact on population health unless spending is allocated to priority health services for groups that currently have little access to services.

Within the sector, tracking of the Abuja target needs to be accompanied by a wider set of performance indicators, such as the ones commonly incorporated in sector-wide approaches—for example, monitoring the proportion of recurrent spending on non-salaries, the proportion of spending allocated to health centres and the proportion of spending going to poorest areas.

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