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Health Financing in Ghana, South Africa and Nigeria: Are They Meeting the Abuja Target?

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Abstract

This paper uses budgetary documents from African health and finance ministries to assess the extent to which African governments are meeting targets set at the Organisation for African Unity Summit, held in Abuja in 2001. Drawing on three case studies (Ghana, Nigeria and South Africa), the authors explore how public healthcare systems are organised; how countries allocate domestic and foreign resources; and whether governments are complying with the Abuja target of spending 15% of government income to achieve health-related Millennium Development Goals, goals for universal coverage of basic healthcare, health equity goals, and financial risk protection. Whilst recognising that this figure is not straightforward to calculate – due to substantial discrepancies in health spending data between national ministries of finance, the WHO, the World Bank and the OECD – the paper argues that South Africa largely meets the Abuja target, whereas Ghana and Nigeria fall short. The paper strongly recommends that the Abuja target may not be the most effective way to improve public health.

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Introduction

In 2001 African heads of state pledged to spend 15% of their government revenue on healthcare at the summit meeting of the Organisation for African Unity in Abuja. In this paper we use country-level budget data to evaluate if this target is being met. In all but a handful of very low income countries, the majority of healthcare spending in Africa is from domestic resources. Effective domestic resource mobilisation is therefore key to achieving health related MDGs, universal coverage of basic healthcare, health equity goals and financial risk protection (see MacIntrye at al 2008, Stenberg at al 2010, Gupta at al 2010, Gostin et al 2010).

In Sub-Saharan Africa the median percentage of healthcare spending that comes from external resources was 20.7% in 2008 (WHO Global Health Observatory). The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action (Box 1) summarise commitments from donor and recipient countries about how to give and receive development aid so that external funds are given and used in a way that is effective and sustainable. Academic research on development aid for health has focused on the impact of external funding on priority-setting, including studies on: the extent to which development aid for health substitutes for domestic funds (see Lu et al 2010, Younde 2010, Farag et al 2009); whose voices get represented in decision making processes (see Garrett 2007, Reich 2002, Hyden 2008, Horton 2009) and the impact of disease specific spending - so-called 'vertical' funding - on the health system as a whole (see Biesma 2009, Atun et al 2009, Piva et al 2009, Shiffman 2008, Atun et al 2010).

Box 1. The Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008)

The Paris Declaration, endorsed on 2 March 2005, is an international agreement to which over one hundred Ministers, Heads of Agencies and other Senior Officials adhered and committed their countries and organisations to continue to increase efforts in harmonisation, alignment and managing aid for results with a set of monitorable actions and indicators.
Ownership - *Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.*

Alignment - *Donor countries align behind these objectives and use local systems*.

Harmonisation - *Donor countries coordinate, simplify procedures and share information to avoid duplication.*

Results - *Developing countries and donors shift focus to development results and results get measured.*

Mutual Accountability - *Donors and partners are accountable for development results.*

The Accra Agenda for Action (AAA) was drawn up in 2008 and builds on the commitments agreed in the Paris Declaration.

Predictability – *donors will provide 3-5 year forward information on their planned aid to partner countries.*

Country systems – *partner country systems will be used to deliver aid as the first option, rather than donor systems.*

Conditionality – *donors will switch from reliance on prescriptive conditions about how and when aid money is spent to conditions based on the developing country's own development objectives.*

Untying – *donors will relax restrictions that prevent developing countries from buying the goods and services they need from whomever and wherever they can get the best quality at the lowest price.*

Source: OECD

In this paper we look at three case studies to assess progress towards the Abuja target, and comment on the pattern of external funding for health. Unlike other studies which rely on donor-provided data and on WHO data (for example Lu 2010), we base our analysis on budget documents from country health ministries and finance ministries. We have three main objectives. First, we describe how the public healthcare system is organised, and what mechanisms control allocation of domestic and foreign resources. Second, we evaluate whether governments are complying with the Abuja target of spending 15% of government income on health, and comment on the different possible ways to calculate this figure. Third, based on country-reported donor receipts where this data was available, we discuss whether this aid spending appears to abide by the principles agreed in the Paris and Accra declaration.

Methods

Ghana, Nigeria and South Africa were chosen because they all had a low level of external funding for health, relative to the other countries in sub-Saharan Africa. This was to increase comparability across the case studies. A further pragmatic consideration was that these three countries' Ministry of Finance, or equivalent, had a functioning website in English.

Data on healthcare funding was collated from official government websites, and data on donor-reported giving and some contextual information were collected from WHO and OECD website. Data were extracted into an excel spreadsheet and analysed using descriptive statistics. Appendix 1 details the sources of all data.

Results

Overall, South Africa meets the Abuja target whilst Nigeria and Ghana do not. However the Abuja target is not straightforward to calculate and it is not necessarily clear what should be in included in either the numerator or denominator. There are large discrepancies between external funding for health as reported by Ghana and South Africa's governments and that captured in OECD and WHO data sets.

Table one shows background data on health and health financing in Ghana, Nigeria and South Africa. Ghana has substantially larger amount of external resources for health (10%) than South Africa or Nigeria, although this is still less than the sub-Saharan Africa median (20.7%). The total resource envelope for health is much larger in South Africa ($497 per capita) than in Nigeria or Ghana ($74 and $54 respectively). Half (51%) of all healthcare spending in Ghana is from public funds, in South Africa this figure is 41% and in Nigeria only 25%. The three countries have a reasonably similar life expectancy overall, although Nigeria has a higher infant mortality rate than South Africa or Ghana. Ghana has the highest percentage of children vaccinated against diphtheria, pertussis and tetanus (often used as a proxy for health system effectiveness). The tax capacity of the country – that is, the ability of the government to raise public funds through tax - is similar in South Africa and Ghana (23% and 27%, respectively), and no data exist for Nigeria [1]. Regarding quality of public administration -

[1] "Grey literature" suggests the tax capacity in Nigeria is lower, at about 11%. See [http://news2.onlinenigeria.com/news/general/17888-Why-Nigerias-tax-system-weak-CITN.html]

that is, capacity to spend public funds effectively - The CPIA public administration indices rate Ghana 4/6 and Nigeria 3/6. Data are not available for South Africa. Transparency international's Corruption Perception Index shows that Nigeria is perceived to have the worst corruption problem (2.5/10).

Table 1. Summary of relevant health and economic data for Ghana, Nigeria and South Africa.

	Ghana	Nigeria	South Africa
Population	23350927	151212254	48793022
GDP per capita (PPP, 2005 US$)	1369.7	1949.6	9331.8
Total health expenditure per capita (current US$)	54.1	74.2	497.1
Public health expenditure as % of total health expenditure	51.2	25.3	41.4
Public health expenditure per capita (PPP, 2005 US$)/p	27.6992	18.7726	205.7994
Public health expenditure as % of total government spending	10.7	6.5	10.8
Private health expenditure as % of total health expenditure	50.3	75.3	59.7
Out-of-pocket expenditure as % of private expenditure on health	39.8	72.1	17.7
External resources for health as % of total spend on health	10	2.8	1.2
Life expectancy at birth	56.6	47.9	51.4
Under-5 mortality rate	72	142.9	65.3
% children aged 12-23 months vaccinated against DPT	87	54	67
% 15-49 year olds HIV positive	1.8	3.6	17.8
Tax revenue as % total GDP	23%	-	27%
CPIA public administration rating (1=low, 6=high)	4	3	-
CPIA transparency, accountability, and corruption in the public sector rating (1=low, 6=high)	4	3	-

Source: a compiled from WHO and World Bank with the most recent data available (2007-8).

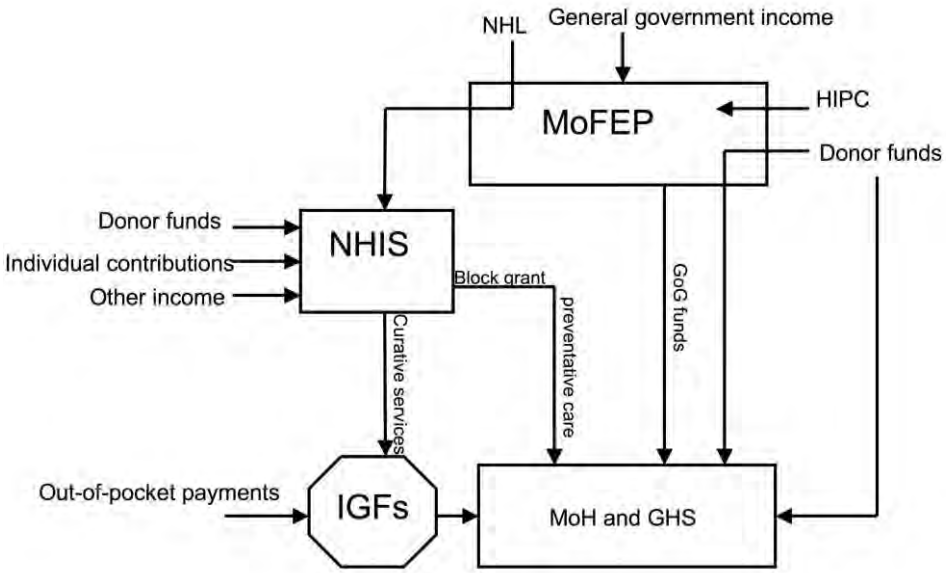
Source: World Bank Databank, World Health Organisation Global Health Observatory and Transparency International

Health Financing in Ghana

Despite having a lower GDP per capita than Nigeria, Ghana spends considerably more on publicly funded healthcare ($27 per person compared to a probable $18.70 in Nigeria). Ghana has recently introduced the National Health Levy, which is a 2.5% VAT-like tax on certain goods and services as an innovative financing mechanism to mobilize resources for health.

Figure 1 shows a simplified diagram of healthcare funding in Ghana. In addition to funding from direct taxation, since 2005 Ghana has had a National Health Insurance Scheme (NHIS). This covers up to 80% of the population, although only 10% of members pay contributions to the scheme - 61% of the income to the scheme comes from the National Health Levy (National Health Insurance Scheme annual report 2008). [2] "Internally Generated Funds" (IGFs) are included in government figures for public spending on health. IGFs represent either NHIS reimbursement to healthcare providers or out-of-pocket payments made direct from households. As well as reimbursing facilities for services provided the NHIS also pays a block grant to the Ministry of Health for preventative services. Ghana is also a beneficiary of the Heavily Indebted Poor Countries (HIPC) programme, which provides financial resources in the form of debt relief, earmarked for poverty-alleviation which in the context of healthcare means primary health care. This complex healthcare envelope is in contrast to Nigeria and South Africa where all reported spending comes from the general budget and government tax income.

Figure 1. Simplified diagram of Ghana public sector healthcare financing



[2] A recent Oxfam report is highly critical of the Ghanaian NHIS (Apoya, P., Marriot, A. Achieving a shared goal: Free universal health care in Ghana. Oxfam UK March 2011. http://oxf.am/Z2D). The authors suggest that as few as 18% of Ghanaians may be covered by the scheme and note that everyone funds the scheme through the NHL tax levy. Ghanaian government estimates up to 80% population are covered by the NHIS.

Key: NHIS: National Health Insurance Scheme. MoFEP: Ministry of Finance and Economic Planning. NHL: National Health Levy. IGFs: Internally Generated Funds. HIPC: Heavily Indebted Poor Countries. MoH: Ministry of Health. GoG: Government of Ghana. GHS: Ghana Health Services.
Table 2 shows donor income for health as reported in budget appendices from the Ghanaian Ministry of Finance and Economic Planning (MoFEP). In the Ghana Medium Term Expenditure Framework (MTEF) from MoFEP $43.9 million of aid for health were planned for in 2009, but in the first three quarters (Jan to Sept) $73.8 million was received.

Table 2. Donor spending for health in Ghana, 2009

	Ghana cedis (x10^6)		US dollars (x10^6)	
	Planned in Medium Term Economic Framework.	Received in first three quarters of year (Jan – Sept)	Planned in Medium Term Economic Framework.	Received in first three quarters of year (Jan – Sept)
HIV	3.10	0.44	2.20	0.31
Earmarked funds	5.62	0.96	4.00	0.68
General funds	50.5	90.0	35.8	63.8
Equipment/buildings	2.65	12.8	1.88	9.04
	61.9	**104.2**	**43.9**	**73.8**

Source: Ghana Ministry of Finance and Economic Planning (MoFEP), Budget Appendices 2009.

The Ghanaian Ministry of Health report that their health spending is 14.6% of total government spending. However, as explored in the following discussion section, it is difficult to form a reliable independent estimate due to double-counting of 'internally generated funds.' The WHO estimate is that healthcare spending represents 10.7% of total government spending (table 1).

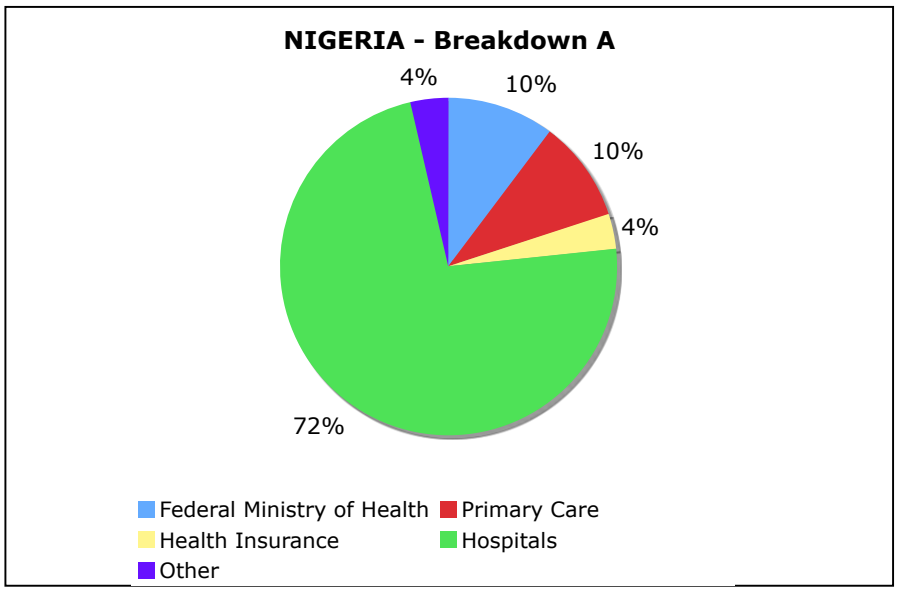
Health Financing in Nigeria

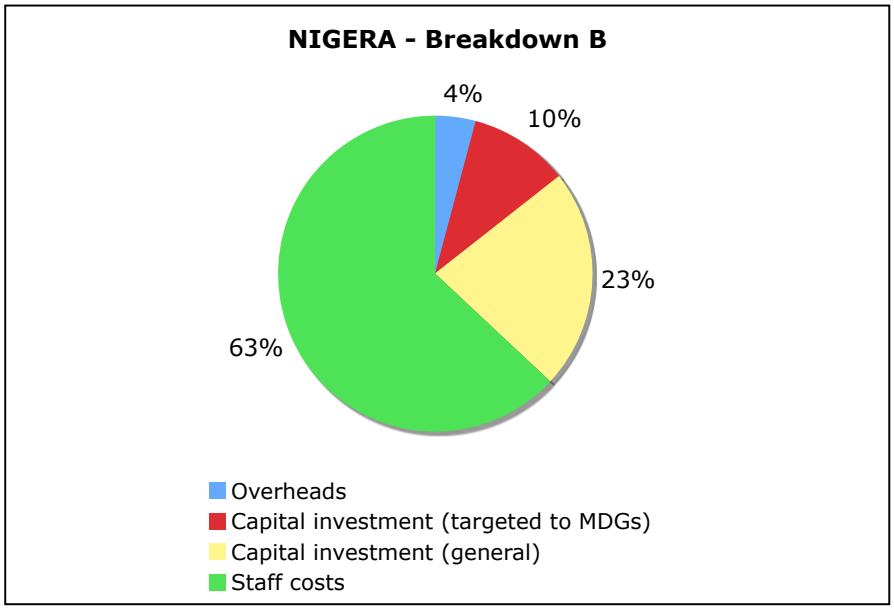
Detailed information was available for the Federal Government spending on the Federal Ministry of Health only. There was no data for spending at the state or provincial level. The total spent was $1037 million, approximately $6.70 per capita. The World Bank records that $18.70 per person was spent from public sources on health. Decentralised spending at state and local level probably explains the $12 difference between these figures. In 2005 (the most recent year for which a budget breakdown is available) the WHO National Health Accounts document for Nigeria show that federal government funded 13% of all healthcare spending, and state and local governments funded a further 13%. If this pattern held in 2009, that would account for some of the discrepancy between the budget document figures and the World Bank report.

Figure 2 shows how federal funding was spent: 63% of the total went to staff costs –this is higher than Ghana (43%) or South Africa (46%). 73% of the total was spent on hospital facilities, and

10% on primary care. Nigeria Budget Office for the Federation does not release any quantitative information about donor support for health, so it was not possible to assess donor funding in Nigeria or to compare patterns of foreign and domestic funding allocations.

Figure 2. Nigeria Federal Government Health Spending, 2009.





Source: Budget Office of the Federation, Nigeria. 2009.

The federal spending on healthcare represented in 2009 6% of total federal spending.

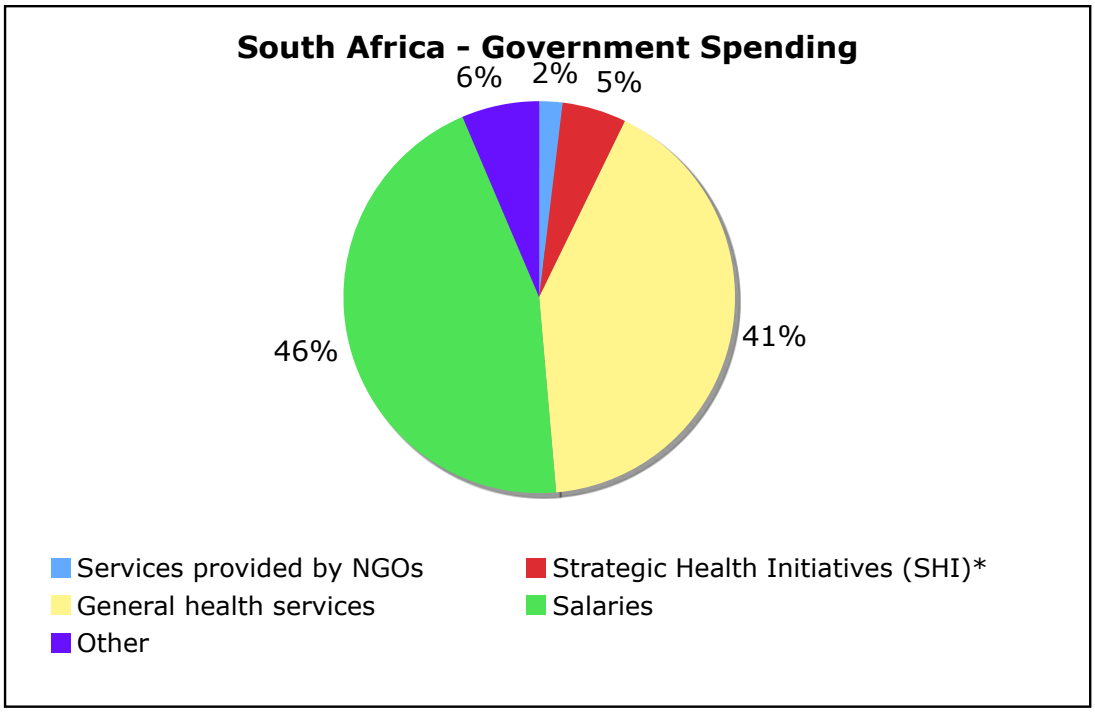
Health financing in South Africa

South Africa has the largest per capita income ($5849) and the highest per capita health spending ($497) of the three countries surveyed here. Unlike Ghana and Nigeria, the financial year runs from 1st April to 31st March, rather than following a calendar year.

The National Treasury has a detailed appendix of donor support for healthcare. External funding from donors captured here represents 0.2% of the government health expenditure in 2008/09. This is significantly lower than the WHO estimate that 1.2% of healthcare funding came from external sources in 2008 (table 1).

Taking the national and provincial government spending together, the items that receive the most funding are healthcare worker salaries (46% of total) and provision of general health services (41%) (Figure 3). Five percent of all South Africa governments funds were spent on "Strategic Health Initiatives" (i.e. 'vertical funds'); 81% of this was for HIV/AIDS.

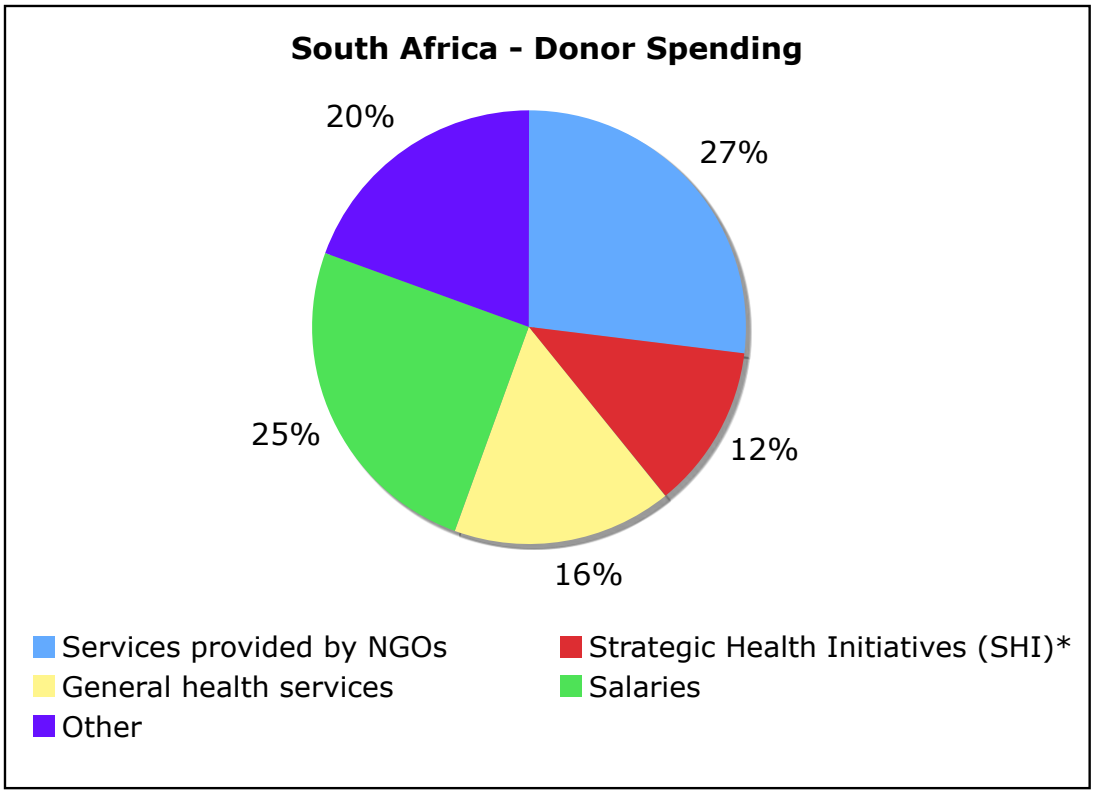
Figure 3. South Africa National and Provincial Spending on Health, 2008/09.



Source: South Africa Treasury, Estimates of National Expenditure 2009.

Donors gave proportionally less funding for salaries and general health services compared to the South African government, and more funding for Strategic Health Initiatives (12%) and for services provided by NGOs (27%) (Figure 4). Ninety percent of donor funds for Strategic Health Initiatives were for HIV/AIDS.

Figure 4. Donor spending on health in South Africa 2008/09.



Source: South Africa Treasury, Estimates of National Expenditure 2009.

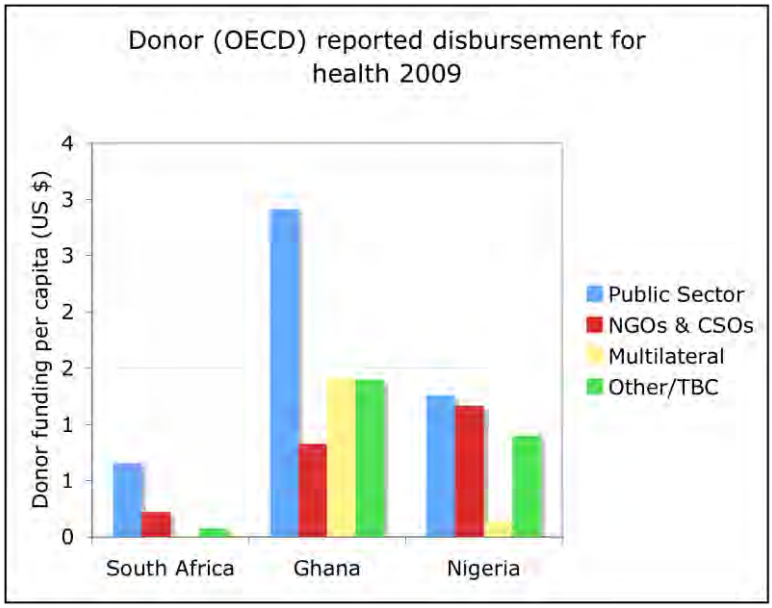
The proportion of spending on health as a percentage of total government spending was approximately 11%.

Donor-reported data

Figure 5 shows donor reported spending on aid for health, as captured in the OECD creditor reporting system. Donors report giving $6.60 per capita to Ghana, $3.50 per capita to Nigeria and $1.00 per capita to South Africa. Sixty seven percent of all aid for health to South Africa was given to the public sector; 44% of donor funding for health to Ghana and 36% in Nigeria was given to the public sector.

The amount of aid reported as received Ghana (table 2) and South Africa (figure 4) do not match that reported as disbursed in the OECD CRS database – as discussed in the next section.

Figure 5. Total disbursed development assistance for health, as reported by major donors, 2009.



Source: Organisation for Economic Co-operation and Development Creditor Reporting System.

Discussion

The Allocation of Funds in-Country

Each of the three countries has a different mechanism for allocating resources for health. Ghana has a social health insurance scheme and uses an innovative financing mechanism (the National Health Levy) to generate funds. This means that to some extent patient choice may determine where money is spent [3]. The result of this funding mechanism is that the Government of Ghana via the Ministry of Health are directly responsible for paying staff salaries – a relatively fixed and recurrent cost – and little else. This means that the Ministry of Health overseen by elected parliament has little leverage of where funds are directed, while the unelected and unaccountable board of the National Health Insurance Scheme may have more power to influence spending (Abekah-Nkrumah et al 2009). The National Health Insurance Scheme does not yet cover all Ghanaians and has been criticised for hampering achievement of universal coverage of healthcare (Witter & Garshong 2009).

In South Africa domestic financing was clearly set out in line with South African strategic health objectives. All domestic funding comes from central tax revenue, unlike in Ghana. About 14% of South African citizens have private health insurance (McIntyre et al 2007), but the rest rely largely on public sector healthcare which is free of charge to children, the poor and the unemployed. Two percent of government healthcare funding was spent through NGOs, largely through the HIV/AIDS block grant. Five percent of funding goes to 'strategic health initiatives' – vertical funds to target a specific priority area as decided by politicians.

[3] The details are beyond the scope of this paper, but the health insurance scheme is only useful in enhancing choice if citizens have a real choice of health facilities. This is not the case in many rural areas of Ghana where there may be only one (or none) accessible healthcare facility.

The process for allocating money to projects in Nigeria is not clear – the ministry of finance produces a line-item budget of disbursed money without explanation. Nigeria spends 63% of federal health spending on staff, this is proportionally more on staff than Ghana (43%) or South Africa (46%). Seventy two percent of federal health spending went to hospitals and 10% to primary care. We were unable to find data in order to comment on decentralised health spending at state and local government level. Nigeria also has a National Health Insurance Scheme which has existed for over ten years. However only civil servants - and in two provinces women and children - are covered by this scheme (Humphreys 2010), and the small volumes of funding mean that this health insurance scheme does not significantly affect the process of resource allocation.

The Abuja target for domestic spending on health

None of the three countries met the Abuja target of spending 15% of government spending on health. This target is often used as an accountability tool by civil society groups, given that African leaders agreed on this number. However it is not clear that tracking progress to this target is the best way to analyse a domestic health financing system. First, we have shown the difficulty of calculating the figure. For example, in Ghana the government reported figure include both Internally Generated Funds (IGFs), and subsides to the NHIS in its calculation towards the Abuja target. A proportion of IGFs come from individual payments and could be more properly seen as 'user fees', and perhaps should not be included as public funding. Most of the remainder of IGFs come from NHIS reimbursement to health facilities, leading to 'double-counting' of NHIS subsidy and NHIS reimbursement. In Nigeria the decentralised nature of public funding of healthcare and lack of collated information on provincial spending means that it is not possible to accurately assess total public funding. Second, the resources that are available for health depend on the income of the country and the tax capacity of the system as much as allocation of public funds. Third, health outcomes are related not just to volume of funds but how resources are spent – with regards to efficiency, equity, population coverage and cost effectiveness of interventions. These factors are much harder to measure, but would give a more valid indicator of the adequacy of domestic financing for health than would looking only to progress towards the Abuja target of 15%.

Donor compliance with Paris Declaration and Accra Agenda.

The principles of the Paris Declaration on Aid Effectiveness 2005 are ownership, alignment, harmonisation, managing for results and mutual accountability. The Accra Agenda for Action (2008) added the principles of predictability, use of country systems, addressing conditionalities and untying aid. These agreements reflect that giving and receiving aid are highly political processes (Hyden 2008). The current study of comparing domestic and international flows of funds allows us to comment – although not to draw firm conclusions - on ownership, alignment, predictability and use of country systems.

One way to look at ownership and alignment with country strategies is to compare funding patterns from domestic funds and foreign aid. This is possible to assess in South Africa, since the National Treasury report foreign aid for health and use the same categories to break down the received fund as are used for domestic spending. Donors were less likely to fund general health services (46% of domestic financing and 16% of foreign aid), and were more likely to fund strategic

health initiatives (5% of domestic money and 12% of foreign aid). Both foreign and domestic strategic initiatives had a strong focus on HIV/AIDS. It is notable that donors are apparently more willing to fund 'vertical' programmes, and programmes where non-governmental organizations deliver the healthcare than general health services and services delivered by government facilities (Sridhar & Tamashiro 2010).

Regarding predictability of aid, Ghana uses a Medium Term Expenditure Framework (MTEF) for designing their country budget. This process is supposed to bring predictability to funding, allowing country ministries to have greater knowledge of financing flows in the near future. However, our data indicates that these funds are not predictable in advance. From Jan-Sept 2009 Ghana received 168% of the predicted funding for health for all of 2009, but often theses funds received were not earmarked for the planned project. For example $2 million donor support for HIV was budgeted in the MTEF, but only $300,000 was received; and $1.3 million of donor funding was expected for health facilities but $9 million was received. The MTEF isn't a forecast of all likely aid, rather it includes external funds only once they have been committed. If donor funding proposal and disbursement cycles are misaligned with domestic financial planning, or if there are delays in disbursement of committed aid then there will be a discrepancy between funding predicted in the MTEF and that actually received. This is problematic because unpredictable aid means that recipients are unable to plan and it may hinder the ability of a recipient to effectively allocate domestic resources because it is unable to know year to year if domestic funds will be needed to 'plug a gap' left by donors (see Lane & Glassman 2007).

In this paper we assessed aid flows captured in country ministry of finance figures. But data from the OECD suggests that this is a minority of all aid received – which could imply that the principles of country ownership and use of country systems are not being adhered to. In South Africa two thirds (67%) of aid for health was given to the public sector, in Ghana this figure was 44% and in Nigeria it was 36%. This indicates that country systems may not be being used as a first option as set out in the Accra Agenda. It is hard to know to what extent this pattern of funding is appropriate to the situation – the CIPA rating for public administration is rather low in Nigeria at 3/6 and Transparency International rates Nigeria at 2.5/10 for perceived corruption. Where public administration is weak it can be argued that money will be spent more efficiently and effectively through other mechanisms, however, if donor aid is spent outside of the public system this may undermine and weaken public administration rather than help to strengthen it (Kolstead 2005). Indeed, when Nigeria's national planning commission asked for details of all development assistance given to Nigeria between 1999 and 2007, major donors were unable or unwilling to share this information [4].

Difficulties in gathering transparent data and discrepancies between sources

A wider issue that is raised by these three cases studies is the difficulty in accurately ascertaining where resources are being spent. The OECD Creditor Reporting System (CRS) database is widely used to study aid flows (e.g. Lu et al 2010 , Piva & Dodd 2009, Ravishankar et al 2009). We found in each case that the amount of disbursed aid for health captured in the OECD CRS did not match the country-reported receipts. For instance the OECD CRS reports that Ghana

[4] "Nigeria: do donors know what they're spending?" David Stevens, Global Dashboard. http://www.globaldashboard.org/2010/03/19/nigeria-donors-spending/ (accessed 15 April 2011)

received $154 million in aid for health in 2009, $68 million of which was to the public sector. However the Ghana Ministry of Finance and Economic Planning report receiving $73.1 million dollars in the period Jan – Sept 2009. Conversely the OECD report that $48 million was given to South Africa in 2009, $32 million of which went to the public sector. The South African Treasury report receiving $21 million dollars in financial year 2008/09. While there are such discrepancies between data sources, it is important to note that these differences are not necessarily irreconcilable—this is particularly true in the case of South Africa because of the differences in financial and calendar years. Some of the apparent discrepancy is likely to be related to differences in donor and recipients in what is classified as development assistance for "health," disbursement delays, and exchange rate alterations. Part of the difference may also lie in the various ways in which aid is given. For example, as shown in Figure 1, the Ghana Health System funding is complex and donors can give aid either to the Ministry of Health, or the Ministry of Finance and Economic Planning for health or to district level health ministries, or to subsidises for the NHIS or as debt relief earmarked for primary care. This complexity, perhaps coupled with weak financial systems, can make funds difficult to accurately track.

We also note that WHO and World Bank data did not always correspond to country reported data on volume of domestic spending. This problem was compounded by the time lag on reporting data through the World Bank and WHO, and by the fact that South Africa ministry of finance reports data in a financial year from 1st April to 31st March, while the WHO, OECD and World Bank use a calendar year format. For instance the World Bank reports that total health spending in South Africa in 2008 was $497 per person, and 41% of this was public sector spending; equivalent to $205 dollars per person. However the South Africa Treasury reports that in from 1st April 2008 – 31st March 2009 the total public spend on health was equivalent to $182 per capita. In 2008 (the most recent year for which data was available) the World Bank reports that Nigeria spent $18.70 per person on public sector health spending, but the Budget Office of the Federation reports federal health spending as $6.80 per person, and no information is provided about provincial health spending. The WHO reports that 1.2% of South African health expenditure came from external resources in 2008, given World Bank reported total spending on health as $497 per person this amounts to $5.96 per person. However OECD reports only $1 per person given to South Africa in DAH in 2008 (with about $0.76 of this going to the public sector) and the South African National Treasury reports receiving only $0.43 per person in 2008/09.

Studying financial flows for health in these three countries has presented challenges, as outlined above. Given this situation, it becomes clear why researchers turn to the World Bank/WHO and OECD datasets. They are clean, relatively complete and easily accessible. However, our case studies here suggest that these large datasets may not correspond to figures available in the country. Due to the political nature of funding allocations, and the risk of misappropriation of funds, transparency of this data is important for two key reasons: first, to prevent explicit corruption and fraud, and second so that civil society and citizens can hold governments to account for appropriate and effective spending decisions.

Conclusion

In this paper we have examined healthcare financing in Ghana, Nigeria and South Africa. The key messages that emerge are: first, the Abuja target of 15% may not be the most helpful way to

improve health outcomes, and even though it seems a simple target, is extremely difficult to assess compliance with. Second, donors do not seem to follow the principles of predictability of aid and use of country systems and may not abide by principles of ownership and alignment. Third, there are substantial discrepancies between health spending (domestic and donor) as recorded by national ministries of finance, compared to that captured in the WHO and World Bank data, and with that noted by the OECD Creditor Reporting System. Lack of access to good local data and uncertainty about accuracy of international data hinders the ability of parliaments, citizens, states and donors to effectively monitor and engage in the process of managing resources for global health.

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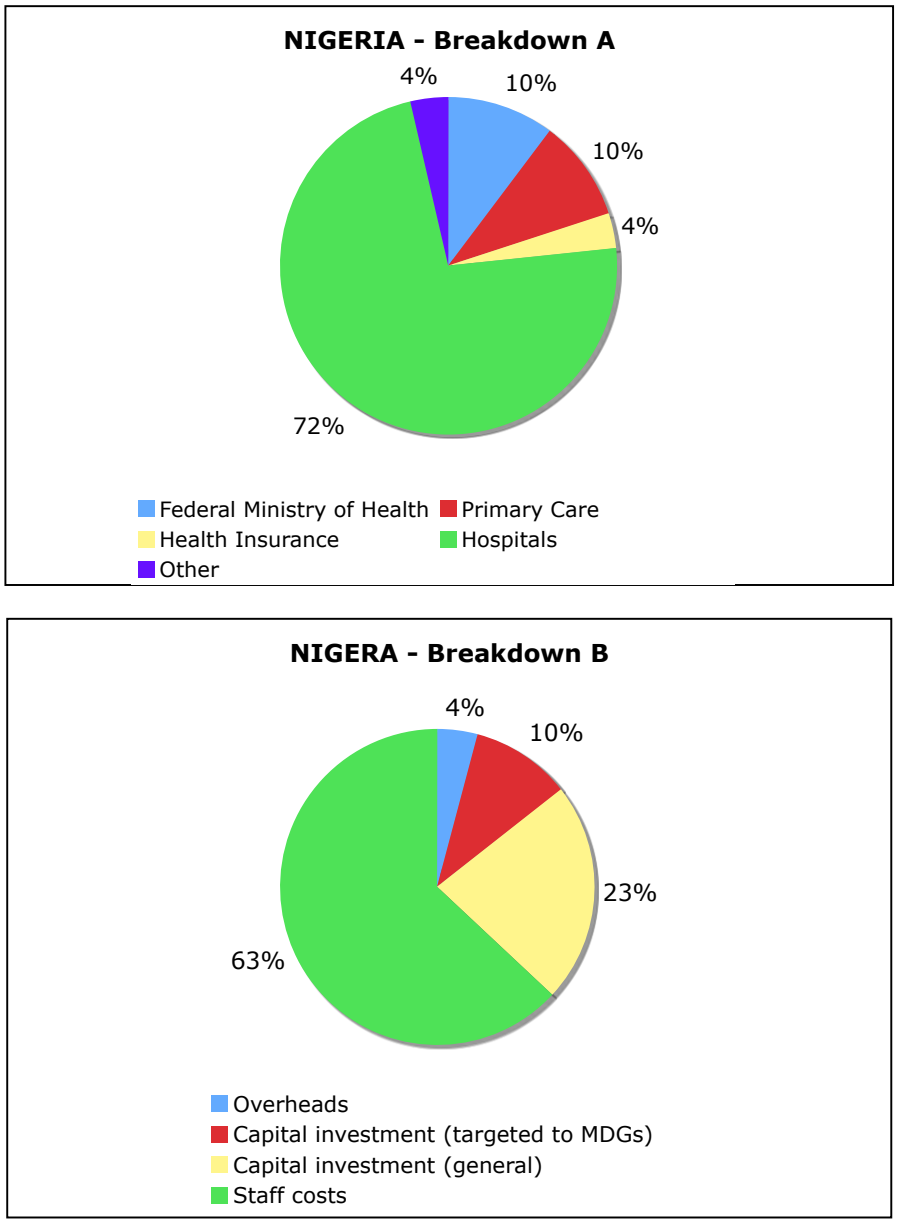
Appendix: The Data Behind the Figures in the Text

Figure 3. Nigeria Federal Government Health Spending, 2009



Source: Budget Office of the Federation, Nigeria. 2009.

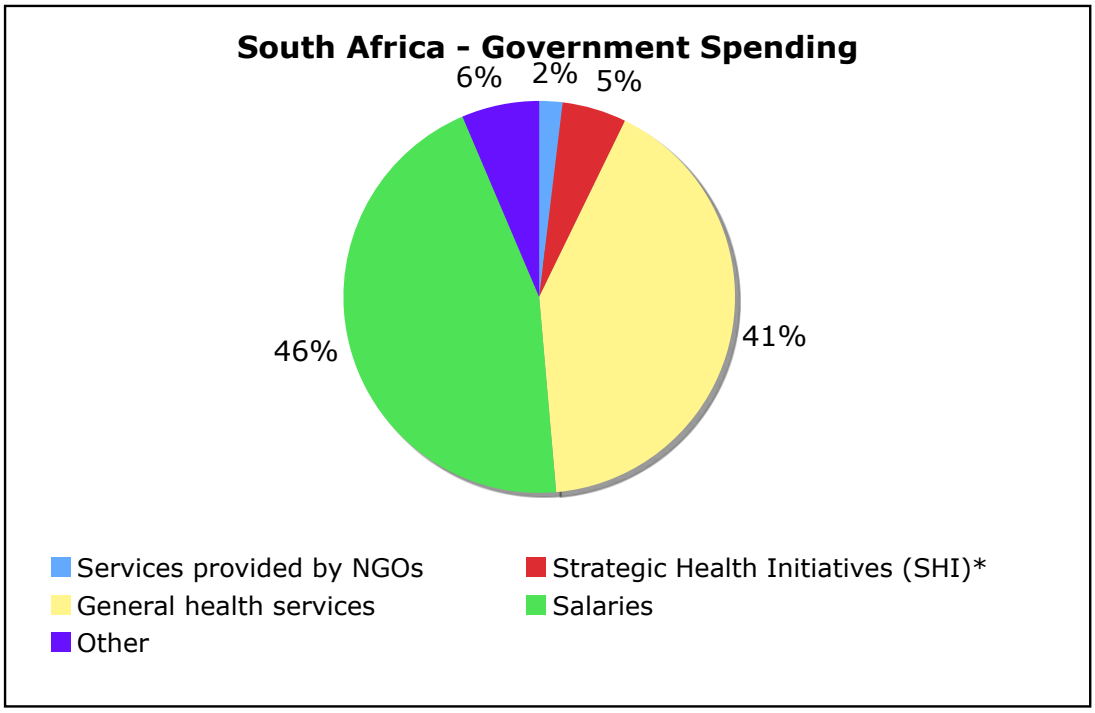
For information – the data for this figure

	Nigerian Naira (x10^6)	US $ (x10^6)	%
Breakdown A			
Federal Ministry of Health	15,670	105	10
Primary Care	14,866	100	10

Health Insurance	5,447	36.6	3.5
Hospitals	111,909	751	73
Other	5,577	37.4	3.6
TOTAL	153,469*	1030	
Breakdown B			
Staff costs	97,341	653	63
Overheads	6,423	43.1	4.2
Capital investment (targeted to MDGs)	15,900	107	10
Capital investment (general)	34,903	234	23
TOTAL	154,567*	1037	

* there were four adding mistakes in the budget data sheet from the Budget Office website, with the results that these figures are not identical.

Figure 4. South Africa National and Provincial Spending on Health, 2008/09



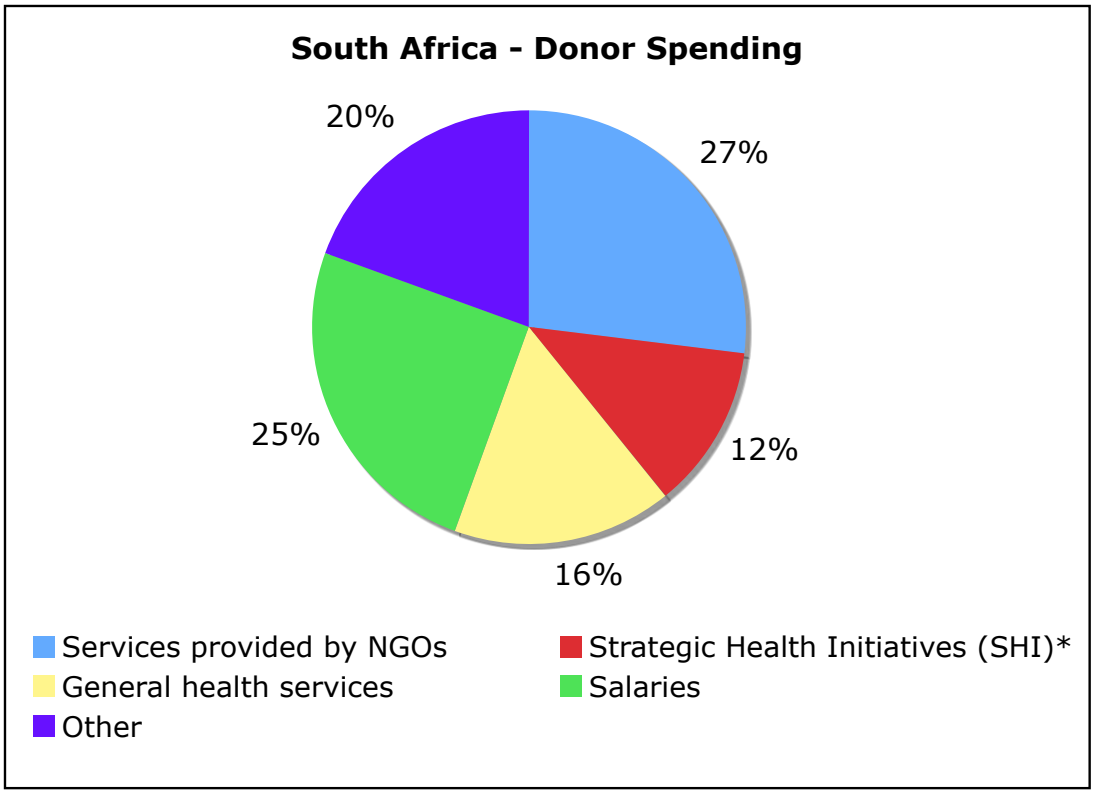
Source: South Africa Treasury, Estimates of National Expenditure 2009.

For information – the data for this figure

	South Africa Rand (x10^6)	USD (x10^6)	%
Salaries	33880	4014	45
Services provided by NGOs	1436	170	1.9
Strategic Health Initiatives (SHI)*	3942	467	5.3
General health services	31071	3681	41
Other	4740	562	6.3
TOTAL	75069	8894	

* NB. 81.4% of government SHI spent on HIV

Figure 5. Donors spending on health in South Africa 2008/09



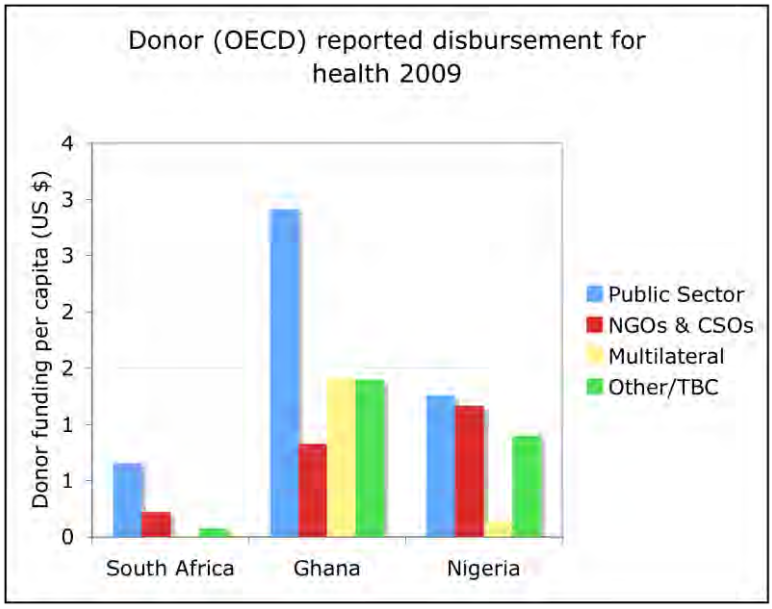
Source: South Africa Treasury, Estimates of National Expenditure 2009.

For information – the data for this figure

	South African Rand (x10^6)	US $ (x10^6)	%
Salaries	44.1	5.23	25
Services provided by NGOs	47.4	5.62	27
Strategic Health Initiatives (SHI)*	22.0	2.61	12
General health services	28.8	3.41	16
Other	34.5	4.09	20
TOTAL	177	21.0	

* NB. 90% donor SHI spent on HIV

Figure 6. Total disbursed development assistance for health (DAH), as reported by major donors, 2009



Source: Organisation for Economic Co-operation and Development Creditor Reporting System.

For information – the data for this figure

> Channel of Delivery ▼ Recipient Country	Public Sector	NGOs & CSOs	Multilateral	Other/TBC	TOTAL
Total (US $ x10^6)					
	Public Sector	NGOs & CSOs	Multilateral	Other/TBC	TOTAL
Ghana	68.1	19.4	32.9	33.5	153.9
Nigeria	190.6	176.7	21.8	136.9	526
South Africa 2009	32.1	10.9	0.7	4.6	48.3
South Africa 2008	*34.1*	*4.3*	*1.0*	*4.8*	*44.7*
Per capita (US $)					
	Public Sector	NGOs & CSOs	Multilateral	Other/TBC	TOTAL
Ghana	2.9	0.8	1.4	1.4	6.5
Nigeria	1.3	1.2	0.1	0.9	3.5
South Africa 2009	0.7	0.2	0.0	0.1	1.0
South Africa 2008	*0.7*	*0.1*	*0.0*	*0.1*	*1.0*
% of donor funding for health by channel of delivery.					
	Public Sector	NGOs & CSOs	Multilateral	Other/TBC	TOTAL
Ghana	44.2%	12.6%	21.4%	21.8%	100%
Nigeria	36.2%	33.6%	4.1%	26.0%	100%
South Africa 2009	66.5%	22.6%	1.4%	9.6%	100%
South Africa 2008	*76.3%*	*9.6%*	*2.2%*	*10.7%*	*100%*

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