Providing health care for the world’s poorest: are governments delivering on their commitments?

Access to good quality free health care is vital in the fight against poverty, yet at present far too many lives are being lost due to inadequate health services in developing countries.

The importance of access to health and medicines is widely recognised as having a significant impact on poverty reduction and as playing an enabling role in promoting development. This role is recognised in the focus given to health in the Millennium Development Goals (MDGs), with improvements in health outcomes at the heart of three of the six goals:

• MDG 4 aims to reduce by two-thirds the under-five mortality rate.
• MDG 5 includes a target to reduce maternal mortality by three-quarters and achieve universal access to reproductive health.
• MDG 6 aims to combat HIV/AIDS, malaria and other diseases and includes targets to halt and begin to reverse the spread of HIV/AIDS, achieve universal access to treatment for HIV/AIDS for all those who need it and begin to reverse the incidence of malaria and tuberculosis.

There is also strong evidence to show that investing in equitable and effective public services for all is a great equalizer. The IMF has recently argued that spending on health and other public services is ‘pro-growth’ and ‘pro-equity’, because when good quality services are available to everyone, they help mitigate the negative impact of economic inequality and address unfair income distribution by providing ‘virtual income’ to the families that need it most. Oxfam estimates that public services top-up the income of the poorest people by as much as 76 per cent.1

For health to play a poverty-busting and equalising role, it is also widely acknowledged that services should be free and publicly provided. Paying for health care can act as a bar to

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accessing services for the poorest. When families are forced into seeking-out costly medical care, this can have a crippling impact on household budgets, pushing millions into deeper poverty. It is estimated that health user fees push 150 million people into ruin every year around the world. Therefore health should be free and universally available.

### Tracking countries spending on health: are they meeting their targets?

Ensuring health care is free and is universally provided takes significant government spending, with most countries currently spending well short of what is needed. This negatively impacts on progress towards the MDGs.

Over a decade ago, two processes were established to give health spending two clear sets of targets. In 2002, at a Special Summit on HIV/AIDS, Tuberculosis and Other Infectious Diseases held in Abuja, Nigeria, African Heads of State committed themselves to allocating a minimum of 15 per cent of government expenditure to health. This became known as the African Union (AU) Abuja commitment, which all 54 governments of the AU are committed to meeting. Globally, the World Health Organization (WHO) Commission on Macroeconomics and Health estimated that the cost of essential interventions to avoid preventable deaths was $30–40 per capita in 2004, on the basis of spending levels in low-income countries with good health outcomes.

Therefore, tracking government spending on how near or far they are from these two financial targets can help to assess efforts towards providing health care and delivering both on the MDG commitments. This briefing, using the data available in the Government Spending Watch (GSW) database, examines the extent to which countries are meeting the spending targets for health. It looks at how well African governments are doing against both of these financial targets, while also tracking other developing countries progress on the WHO global target.

#### What is Government Spending Watch?

The Government Spending Watch (GSW) database is the first ever to track how much developing countries are spending on the MDGs. Currently, the GSW database - a joint initiative by Oxfam and Development Finance International – has spending data across the MDGs sectors for 52 low- and lower-middle income countries from 2008 through to 2013. Over the coming years there are plans to extend the data available to significantly more countries, while the 2014 report aims to analyse spending patterns across 68 countries.

The data, research, and information on current campaigns on MDG spending, are available from the GSW website: [www.governmentspendingwatch.org](http://www.governmentspendingwatch.org). For more information or to make enquiry about how to use the data email: gsw@development-finance.org

As Figure 3.1 shows, of the 32 African countries covered by GSW, only Malawi has succeeded (in 2011) in allocating more than 15 per cent of its spending to health, and thus meeting the AU Abuja commitment. Ten countries (Burundi, Central African Republic, Comoros, Djibouti, the DRC, Lesotho, Liberia, Rwanda, Tanzania, and Zambia) spend more than 10 per cent, and six (Burkina Faso, Ghana, Mali, Mozambique, Sierra Leone and Uganda) are close to 10 per cent.

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3 In some countries data is not available for some years or in some sectors.
However, three (Côte d’Ivoire, Nigeria and Senegal) only spend around 5 per cent – well below the Abuja target. The lack of progress on finance targets and woefully low spending in some countries has very negative impact on access to healthcare. For instance, every single day, Nigeria loses about 2,300 under-five year olds and 145 women of childbearing age die. In relation to the WHO target, only 6 of 32 African countries (Angola, Cape Verde, Congo, Djibouti, the DRC, and Lesotho) exceed it (see Figure 3.2). Ghana and Zambia are within the spending range ($30–40 per capita); and the other 22 countries all spend $20 or less per capita on health. Eight countries (Central African Republic, Ethiopia, Guinea-Bissau, Madagascar, Niger, Sierra Leone, The Gambia, and Uganda) spend less than $10 per capita on health via the government’s budget. This is simply not enough to bring lifesaving services to all, with only 1 in 5 countries meeting the recommended minimum level of spending, and 1 in four spending less than a third of the recommended amount needed.

For non-African countries, the picture appears to be more positive (see Figure 3.3). Eleven out of 19 countries are spending above the WHO upper target ($40 per capita), and therefore meeting that target, even if adjusted for annual inflation of 3 per cent since 2004. However, the eight other countries (Afghanistan, Bangladesh, Cambodia, Haiti, India, Nepal, Tajikistan and Yemen) spend far below the WHO levels. This still means that well over one third of all countries are spending below the WHO recommended amount of minimum spending.

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5 These have only been analysed according to the WHO finance target as these countries are not signed up to the AU Abuja 15 per cent target
Trends in spending: is health spending increasing over time?

Perhaps most worrying of all is that countries appear to be struggling, particularly in the post-financial crisis landscape, to raise spending. The majority of countries have cut the percentage of spending on health, meanwhile average spending has been falling since 2009. After initial rises in health spending in some countries in 2009, two-thirds of countries have seen decreases in health spending (see Figure 3.4) compared with GDP and total expenditure (which is used to assess the Abuja target). In real terms, about two-thirds of countries have managed to continue increasing health spending, but by less than 3 per cent a year. Across all countries covered by the GSW database, government health spending rose by only half as much as education between 2008 and 2012 (a fractional 0.17 per cent of GDP).

Finally, the analysis of the GSW database also showed a difference in spending trends across IMF and non-IMF programme countries, suggesting restrictions imposed by the IMF may be
constraining governments’ capabilities to continue to grow their health spending. In IMF programme countries, spending fell back in 2010 and 2011 after a sharp rise in 2009, while in non-IMF programme countries, it continued to rise until 2011. The overall rise for non-IMF countries was almost twice that for IMF countries, widening the degree to which non-IMF countries spend more on health, to 0.55 per cent of GDP. This deserves further investigation, since it appears to be at odds with the focus of IMF programme “anti-poverty” spending floors on health.

**Figure 3.4: Percentage of countries increasing health spending, 2009-12**

[Pie charts showing percentage of GDP, total expenditure, and local currency (inflation-adjusted) spending changes]

**Where to now?**

Far too many countries are already too far away from reaching the health financial targets, and investments in health in many countries are stagnating. With less than 500 days left to fulfill the MDGs this is no time to be reducing or slowing down spending. Estimates suggest that in 2015 one million child deaths will still need to be prevented to achieve the MDG goal 4 of cutting child deaths by two-thirds. On current progress, the world will not meet MDG 4 until 2028, which is 13 years later than the target deadline. Meanwhile, to meet the target of reducing maternal mortality by two-thirds, progress would need to be quadrupled between now and 2015.

It is a modern day scandal that so many millions of poor women and men are denied their right to health care. Governments need to start investing more, and upping their financing to offer free, universal health care for all, to ensure it can play a role in reducing poverty and building more equitable societies. Clearly increasing spending on health is only one part of this complex puzzle - but it is a vital part.