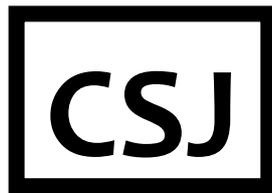


# **Engaging the Approved 2016 Federal Health Budget**



**CENTRE FOR SOCIAL JUSTICE (CSJ)**  
*(Mainstreaming Social Justice In Public Life)*

# Engaging the Approved 2016 Federal Health Budget



**CENTRE FOR SOCIAL JUSTICE (CSJ)**  
*(Mainstreaming Social Justice In Public Life)*

**First Published in 2016**

**By**

**Centre for Social Justice (CSJ)**

**17 Yaounde Street, Wuse Zone 6,**

**Tel: 08055070909**

**Website: [www.csj-ng.org](http://www.csj-ng.org) Email: [censoj@gmail.com](mailto:censoj@gmail.com)**

**Facebook: Centre for Social Justice, Nigeria. Twitter: @censoj**

**CSJ asserts the copyright to this publication.**

## Table of Contents

<b>EXECUTIVE SUMMARY</b> .....	<b>1</b>
<b>1. MOTIVATION</b> .....	<b>3</b>
1.1 Rationale for Increased Domestic Spending on Health .....	4
1.2 Indices of Improvement in the Health Status of Nigerians .....	4
<b>2 GLOBAL TREND OF DEVELOPMENT IN HEALTH</b> .....	<b>9</b>
<b>3 FEDERAL GOVERNMENT ALLOCATION TO HEALTH</b>	
<b>SECTOR IN NIGERIA</b> .....	<b>14</b>
3.1 The 2016 Allocation .....	14
3.2 Comparison with Other Sectors .....	16
3.3 Health Sector Allocations over the Years .....	18
3.4 Utilisation of Allocated Funds .....	20
3.5 The Health Budget had no Underlying Medium Term Sector Strategy .....	22
3.6 No Provision for the Basic Health Care Provision Fund .....	22
3.7 Donor Funds were not Identified in the Budget .....	22
<b>4 LESSONS FOR IMPROVED HEALTH FUNDING</b> .....	<b>23</b>
<b>5 CONCLUSION</b> .....	<b>24</b>
<b>6 REFERENCES</b> .....	<b>25</b>

## Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BHCP	Basic Health Care Provision
BOF	Budget Office of the Federation
CRF	Consolidated Revenue Fund
FGN	Federal Government of Nigeria
FMoH	Federal Ministry of Health
HIV	Human Immunodeficiency Virus
HSMTSS	Health Sector Medium Term Sector Strategies
LMIC	Lower Middle Income Countries
MDA	Ministries, Departments and Agencies of Government
MDGs	Millennium Development Goals
MNCH	Maternal, New Born Child Health
MTEF	Medium Term Expenditure Framework
MTSS	Medium Term Sector Strategy
SDGs	Sustainable Development Goals
SHMC	State House Medical Centre
SSA	Sub-Saharan Africa
UN	United Nations
WHO	World Health Organisation

## List of Figures and Tables

Figure 1	Average Life Expectancy in Nigeria
Figure 2	Neonatal, Infant and Under-5 Deaths in Nigeria
Figure 3	Number of Maternal Deaths and Maternal Mortality Rate in Nigeria
Figure 4	Average Life Expectancy at Birth according to Regions and Income Group
Figure 5	Proportional Allocation of Health Sector Budget in 2016 to Recurrent and Capital Expenditures
Figure 6	Comparison of Sectoral Allocations in the 2016 FGN Budget
Figure 7	Trends of Recurrent and Capital Expenditures: Allocations to Health Sector in FGN Budget

## Tables

Table 1	Ranking of Countries according their Average Life Expectancy at Birth (2014)
Table 2	Trend of FGN Allocation to Health Sector as Percent of FGN Total Budget
Table 3	Health Capital Budget Allocation, Releases, Cash Backed and Utilisation

## **ACKNOWLEDGEMENT**

Centre for Social Justice acknowledges the research and industry of David Onyinyechi Agu in the production of this study.

## EXECUTIVE SUMMARY

The new administration of the Muhammadu Buhari-led Federal Government wanted to prepare a zero-based budget for the 2016 fiscal year. After presenting the proposed budget to the National Assembly on 22 December 2015, the National Assembly spotted out a lot of errors in the budget proposed and presented by the executive arm of the Federal Government. There was therefore a delay in the passage of the budget by the National Assembly. This gave room for many civil society organisations to pick up and analyse the proposed budget based on their sectors of interest. However, on 23 March 2016 – three months after the presentation of the proposed budget, the National Assembly amended and passed the budget. There was further delay in addition to the one by the National Assembly, when the President did not assent to the bill from 23 March 2016 up to the 6 May 2015.

Interestingly, the 2016 budget happens to be the first full fiscal year's budget that has been prepared by the current administration. This study is therefore an analysis of the 2016 Appropriation Act allocation to the health sector. As contained in this study, several observations are made in the approved budget of the health sector. First of all, the approved budget for the health sector represents only 4.13 percent of the entire budget of the Federal Government of Nigeria and at the same time represents a decline of about -3.73 percent from the 2015 budget allocation to the sector. Secondly, out of the amount allocated to health sector in the 2016 Federal Government budget, 88.54 percent are allocated to recurrent expenditures, while only 11.46 percent are allocated to capital projects.

Therefore, the study concludes that the 2016 budget allocation of the Federal Government of Nigeria to the health sector does not reflect the realities that donor agencies are gradually exiting health sector funding from 2016. There is an increase in the overall budget of the Federal Government of Nigeria, whereas the allocation to health sector does not reflect the increase, instead a decrease. The study also observed that greater attention is focused on security issues in the 2016 budget of the Federal Government of Nigeria, whereas malaria alone (as a health issue) kills more than 10 times the number of Nigerians that are violently killed due to insecurity, violence and lack of infrastructures. The health sector should therefore attract more fiscal attention than any other issue especially as Nigeria's health outcomes are still very low relative to other countries within the same economic status.

The study recommends that the following steps should be taken:

- ❖ Increased allocation to the health sector to reach the 15 percent Abuja Declaration benchmark. The bulk of the new resources should go to capital expenditure to enhance access to equipment and health supporting infrastructure.
- ❖ The implementation of the National Health Act setting aside not less than 1 percent of the Consolidated Revenue Fund to the Basic Health Care Provisions Fund.
- ❖ Guarantee the preparation of Health Sector Medium Term Sector Strategies to inform the 2017 federal budget.
- ❖ Increasing the efficiency of health sector spending through greater value for money strategies. Ensure strict and efficient implementation of the resources allocated to the health sector.

- ❖ Public private partnership schemes in the health sector should be encouraged but made as transparent and efficient as possible. This will ensure that the areas that the public sector cannot delve into as a result of cash crunch, the private sector actors can augment and fill the funding gaps. However, necessary caution must be applied in adopting the public private partnership model of health funding in order not to price public health facilities beyond the reach of the ordinary Nigerian.
- ❖ FGN should explore innovative funding mechanisms for the health sector including compulsory universal health insurance scheme for all Nigerians.
- ❖ The FMoH should embrace civil society as a critical partner in achieving greater value for money in a bid to improve national health outcomes.
- ❖ Civil society should start the 2017 budget engagement process early enough with interventions in the MTSS, pre budget memorandum and analysis to inform the new budget of 2017.

## 1. MOTIVATION

Since the beginning of the Fourth Republic, Nigeria has been ruled by three previous administrations before the current one. It was in 2015 that the current administration of President Muhammadu Buhari took over power from the administration of Ex-President Goodluck Ebele Jonathan. The new administration came into power with the promise of change. This explains why the 2016 budget of the Federal Government of Nigeria is captioned “The 2016 Budget of Change”. This is the first budget of the new administration. As a norm, budgets proposal for the next fiscal year is usually presented to the National Assembly within the last quarter of the previous fiscal year. The presentation is made at such a time as to give time for proper scrutiny of the overall focus of the budget and even the line items in the budget. It is expected that the National Assembly will usually consider the budget and make necessary corrections before approving the budget and presenting it for presidential assent so that it becomes the Appropriation Act.

In line with the norm, the executive arm of the administration presented the Federal Government’s budget for the 2016 fiscal year to the National Assembly on 22 December 2015. However, the National Assembly could not pass the budget until 23 March 2016 – three months later. The delay in the process of passage of the Appropriation Bill was blamed on the irregularities found in the proposed budget as presented by the executive arm of the Federal Government of Nigeria. In addition to the delays by the National Assembly in passing the budget, the President did not assent to the bill immediately. It took another two months, precisely on the 6<sup>th</sup> of May 2015 before the President assented to the Appropriation Bill and it became the 2016 Appropriation Act.

The 2016 budget was prepared as a zero-based budget, contrary to the previously known method of incremental budgeting. As novel as the idea of a zero-based budgeting system may be, the new policymakers did not take into account the level of knowledge of the civil servants in relation to zero-based budgeting. This is because the onus of preparing the budget would still fall on the civil servants. Therefore, their level of understanding of the subject matter was crucial in the implementation process. Lack of understanding of the new method is believed to have contributed immensely to the irregularities that were detected by the National Assembly, thereby leading to the delays in both passing and signing the Appropriation Act by the National Assembly and the President respectively.

Before being passed, the proposed budget was analysed by various stakeholders and their recommendations were sent to the National Assembly for consideration and to be taken into account in the correction/approval process. Given the delay in the approval process, one should think that all the recommendations and suggestions in the various analyses should have been incorporated into the approved budget. This study therefore seeks to analyse by what extent, the approved health sector budget differs from the proposed budget. This is to be able to show the extent to which the recommendations of the various stakeholders have been reflected in the approved health sector budget.

### ***1.1 Rationale for Increased Domestic Spending on Health***

Nigeria's primary health care has been enjoying a lot of aid from foreign multilateral agencies. Most of the vaccines used in Nigeria are usually subsidised. However, granting of the subsidies is based on the ranking of the recipient countries – low income countries. As is the expectation of any low income country, Nigeria grew above being classified as a low income country, and therefore joined the league of lower middle income countries in 2014 (UN, 2015).

The growth of Nigeria and consequent transition to the league of lower middle income countries came with a price. Recall that the condition for most of the multilateral agencies to continue subsidising vaccines and other basic health consumables is that the recipient country should be considered a low income country. This implies that Nigeria is no longer eligible to receive subsidies on vaccines and other health consumables. The subsidies and interventions of these agencies go a long way in augmenting Federal and State Governments' annual allocation to the health sector in order to bring about the expected health outcomes.

Every arrangement for the donor agencies to exit funding and subsidising of Nigeria's health sector has been concluded. For instance, Global Alliance for Vaccines and Immunization (GAVI) is one of the major multilateral agencies that have been subsidising Nigeria's health sector through supply of vaccines and immunisation materials at no cost. Based on Nigeria's economic growth, GAVI has planned a gradual exit that will lead to total withdrawal of its funds by 2020. To achieve this goal, the agency has strategized to withdraw 20 percent of its contributions to healthcare funds in Nigeria annually from 2016 to 2020. The implication is that beginning from 2016, vaccines that were previously at no cost will attract 20 percent of their market values. Additional 20 percent will be placed on the products by 2017 to attract 40 percent of the market values as the products are imported into Nigeria. This will continue until 2020 when 100 percent of the subsidy on vaccines and immunisation materials would have been removed from Nigeria (Tyessi and Okeke, 2015).

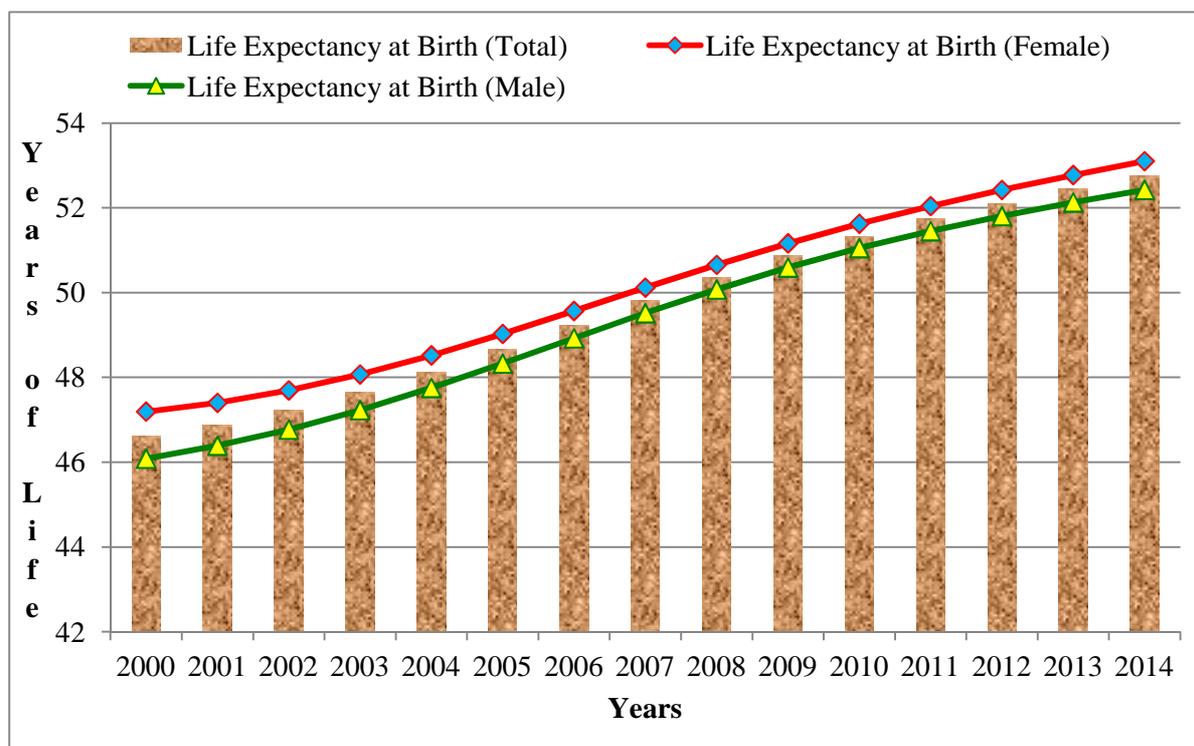
The implication of the exit strategy shown above is that Nigerian governments should increase annual allocation to the health sector by at least 20 percent of the amount they have been receiving as subsidies from the donor agencies from 2016. The country will not be able to maintain at least the same level of health services without adequate increase in the amount allocated to health sector over the 2016 – 2020 fiscal years. The need to increase allocation so as to accommodate the removed subsidies does not only concern the 2016 budget of the Federal Government of Nigeria, but also those of the States governments.

### ***1.2 Indices of Improvement in the Health Status of Nigerians***

Discussions on fiscal allocation of the Federal Government of Nigeria to the health sector cannot be complete without discussion on the current status of health indices in Nigeria. There are several indices or indicators of improved health status. Some of the indicators used for the Millennium Development Goals (MDGs) and those of health-related goals in the current Sustainable Development Goals (SDGs) can be used in ascertaining the extent to which a country's health status has improved over time.

Given that discussion on all the indicators will amount to a study of their own, it becomes necessary to only consider some of the indicators that may likely present some facts about the health status of Nigerians. Some of the indicators that need to be considered are: average life expectancy; neonatal mortality rates; infant mortality rates; under-5 mortality rates; and maternal mortality ratio, etc.

*Figure 1: Average Life Expectancy of a Nigerian*



*Source: World Bank (2016) World Development Indicators*

As at 2000, the average life expectancy of a Nigerian at birth was merely 46.62 years. There was a relatively wide gap between the average life expectancy of a Nigerian woman and that of a man. This is justified on the fact that globally, women seem to live longer than men. The average life expectancy of a Nigerian female was 47.19 years, while that of a Nigerian man was 46.08 years. However, improvement in health services and improvement in the living standards of many Nigerians led to increase in the expected lifespan of an average Nigeria within the study period of 2000 – 2014. The average life expectancy of a Nigerian (and those of male and female alike) maintained an upward trend throughout the period of 2000 – 2014. It is interesting to know that as at 2014, average life expectancy of a Nigerian at birth had risen to 52.75 years. Disaggregating the average into male and female, we observe that the average life expectancy of a Nigerian female as at 2014 had risen to 53.10 years, while that of a Nigerian man had also risen to 52.43 years.

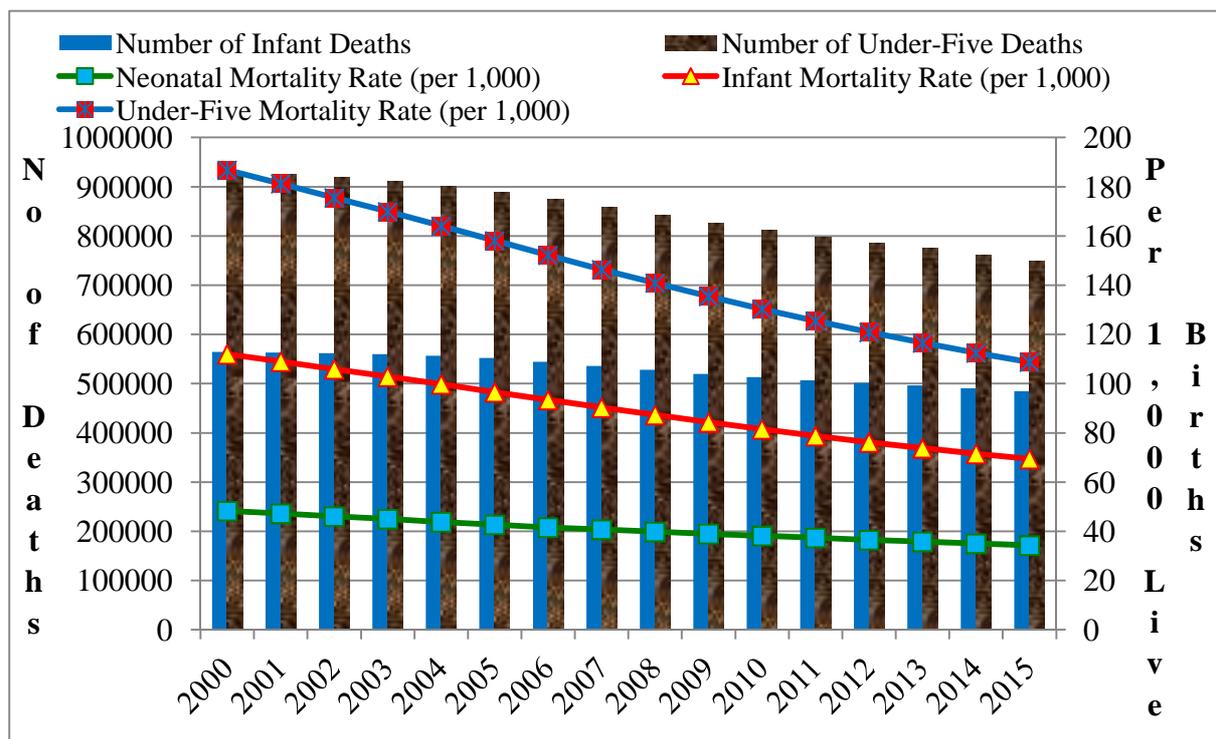
From the above, we can infer that the average life expectancy of a Nigerian (generally) at birth improved by 13.15 percent from its 46.62 years in 2000 to 52.75 years in 2014. Disaggregating the improvement into male and female, we also infer that the average life expectancy of a Nigerian female at birth improved by 12.52 percent from its 47.19 years in 2000 to 53.10 years in 2014. On the other hand, the average life expectancy of a Nigerian

male at birth improved by 13.76 percent from its 46.08 years in 2000 to 52.43 years in 2014. These improvements can easily be attributed to improvement in health services rendered to Nigerian citizens.

Other important indicators of improvement in health services and consequently health status of Nigerians include newborn, infant, child, and mother mortality rates (neonatal, infant, under-five, and maternal mortality rates). These are important indicators of health related goals in the Millennium Development Goals (MDGs) of 2000 – 2015 and the Sustainable Development Goals (SDGs) of 2015 – 2030. To buttress the importance of these indicators, maternal and child health are considered very important in the current 2030 Sustainable Development Goals. This explains why the duo became the first two targets of Goal 3 (Health related goal) in the current 2030 Sustainable Development Goals.

Therefore, it is important that we consider the level of improvement in these indicators as they relate to Nigerians. It is possible to establish a correlation between improvements in maternal and child health on one hand, and improvement in life expectancy rate on the other hand. The indicators will serve to inform policymakers on the area of health services that still need to be improved in order to achieve the goals of annual fiscal spending on health sector.

Figure 2: Neonatal, Infant & Under-Five Deaths in Nigeria



Source: World Bank (2016) World Development Indicators

Neonatal mortality rate shows the probability that a newborn dies within few days or immediately after being born. Figure 2 above shows that neonatal mortality rate in Nigeria was as high as 48.3 neonatal deaths out of every 1,000 live births as at 2000. There was impressive reduction between 2000 and 2015 fiscal years in neonatal mortality rate. Neonatal mortality rate maintained a downward trend throughout the study period of 2000 – 2015. This

explains why as at 2015, neonatal mortality rate in Nigeria reduced by 28.99 percent from its rate of 48.3 neonatal deaths out of every 1,000 live births in 2000 to the rate of 34.3 neonatal deaths out of every 1,000 live births.

Similarly, infant mortality rate shows the probability that an infant dies before marking his/her second birthday. Figure 2 above shows that infant mortality rate in Nigeria was as high as 112 infant deaths out of every 1,000 live births as at 2000. Just as with neonatal mortality rate, there was also impressive reduction in infant mortality rate between 2000 and 2015 fiscal years. Infant mortality rate maintained a downward trend throughout the study period of 2000 – 2015. This explains why as at 2015, infant mortality rate in Nigeria reduced by 38.04 percent from its rate of 112 infant deaths out of every 1,000 live births in 2000 to the rate of 69.4 infant deaths out of every 1,000 live births.

The health of a nation is usually calculated with the probability that younger generations will grow to the point of replacing the older generations. Under-five mortality rate shows the probability that a child dies before marking his/her fifth birthday. Figure 2 above shows that under-five mortality rate in Nigeria was as high as 186.8 under-five deaths out of every 1,000 live births as at 2000. The same pattern observed in neonatal mortality rate and infant mortality rate was also observed in under-five mortality rate. There was impressive reduction in under-five mortality rate between 2000 and 2015 fiscal years. Under-five mortality rate maintained a downward trend throughout the study period of 2000 – 2015. This explains why under-five mortality rate in Nigeria reduced by 41.76 percent from its rate of 186.8 under-five deaths out of every 1,000 live births in 2000 to the rate of 108.8 under-five deaths out of every 1,000 live births in 2015.

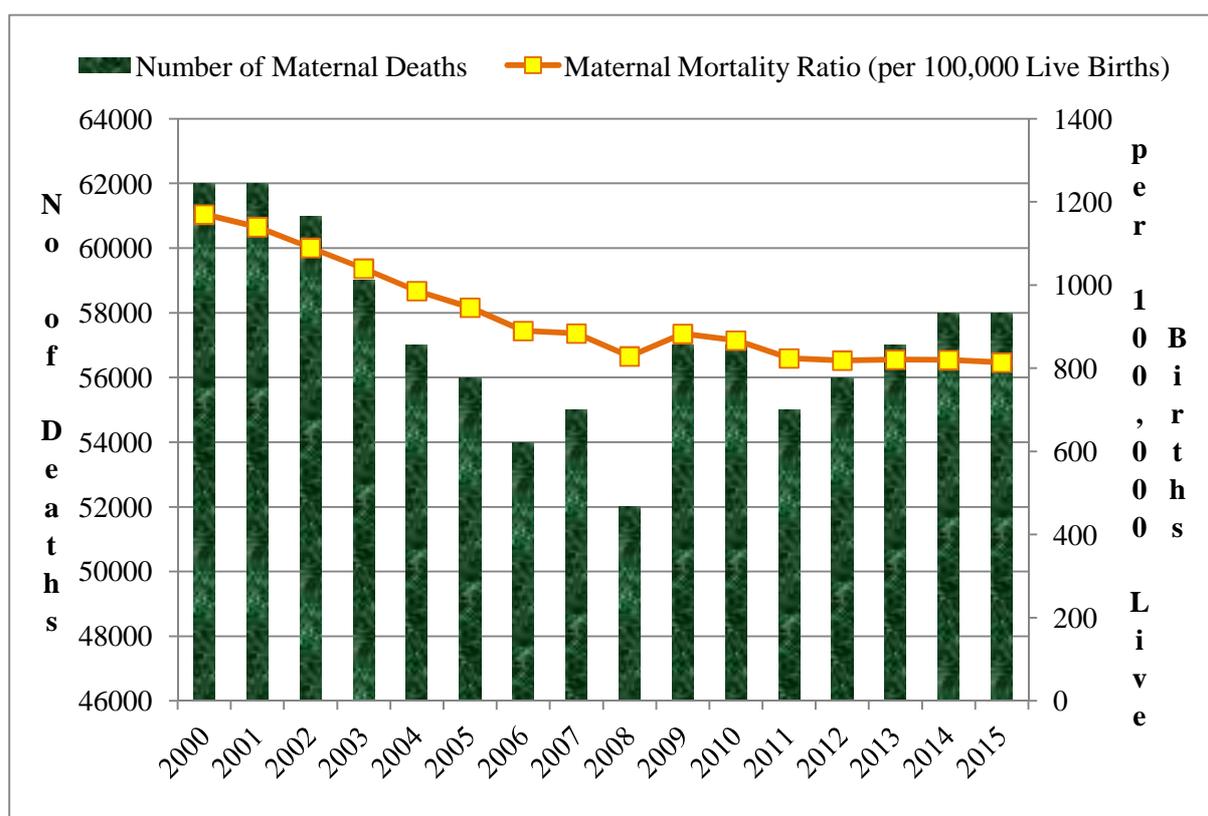
From the analysis above, neonatal mortality rate, infant mortality rate and under-five mortality rate recorded impressive reductions between 2000 and 2015. However, when the absolute numbers of infant and under-five deaths are considered as indicators for measuring progress in overall outreach of healthcare services, we observe that the story is different. Though, there were reductions in the absolute numbers of infant and under-five deaths, yet the reductions were not as impressive as those of mortality rates, or were not impressive at all.

Figure 2 above shows that there were some forms of reduction in the absolute number of infant deaths in Nigeria over the study period of 2000 – 2015. Comparing the decline in the absolute number of infant deaths in Nigeria with the observed declines in infant and neonatal mortality rates discussed above, one can conclude that the decline in the absolute number of infant deaths in Nigeria between 2000 and 2015 is not significant. As at 2000, the total number of infant deaths stood at 564,728 infants. The number of infant deaths maintained a gradual declining trend from 2000 till 2015. As at 2015, the absolute number of infant deaths had recorded a decline of 14.23 percent from its value of 564,728 infant deaths in 2000 to 484,368 infant deaths in 2015 fiscal year. It is clear that the 14.23 percent reduction in the absolute number of infant deaths cannot compare with the 38.04 percent reduction in infant mortality rate.

In the same way, Figure 2 above also shows that there were some forms of reduction in the absolute number of under-five deaths in Nigeria over the study period of 2000 – 2015. However, comparing the decline in the absolute number of under-five deaths in Nigeria with the observed decline in under-five mortality rate as discussed above, one can also infer that the decline in the absolute number of under-five deaths in Nigeria between 2000 and 2015 is not significant. As at 2000, a total of 929,285 under-five children died in one year only. The number of under-five deaths maintained a gradual declining trend from 2000 till 2015. As at 2015, the absolute number of under-five deaths recorded a decline of 19.28 percent from the total death of 929,285 under-five children in 2000 to a total death of 750,111 under-five children in 2015 fiscal year. In like manner, it is clear that the 19.28 percent reduction in the absolute number of under-five deaths cannot compare with the 41.76 percent reduction in under-five mortality rate per 1,000 live births.

It will also be necessary to present the current status of maternal health in Nigeria over the years. This entails presenting the trend of maternal mortality and maternal mortality ratio in Nigeria. Figure 3 below is a graphical presentation of the trend in maternal mortality and maternal mortality ratio between 2000 and 2015.

*Figure 3: Number of Maternal Deaths & Maternal Mortality Rate in Nigeria*



**Source:** World Bank (2016) World Development Indicators

Any country that will not want to experience generational gap must not toy with the health of its women of reproductive age and that of the children. We have presented the current status of health of children (under-five children, infants and newborns). It is equally important to consider what has happened with respect to mothers. Figure 3 above presents the current

trend in maternal mortality ratio and absolute number of maternal deaths. Maternal mortality ratio shows the probability that a pregnant woman dies during child birth or from complications emanating from childbearing. Figure 3 above shows that maternal mortality ratio in Nigeria was as high as 1,170 maternal deaths out of every 100,000 live births as at 2000. Interestingly, maternal mortality rate recorded impressive reduction between 2000 and 2015 fiscal years. The impressive reduction was as a result of the downward trend maintained by maternal mortality rate almost throughout the study period. As at 2015, maternal mortality rate in Nigeria had reduced by 30.43 percent from its value of 1,170 maternal deaths in every 100,000 live births in 2000 to the value of 814 maternal deaths in every 100,000 live births.

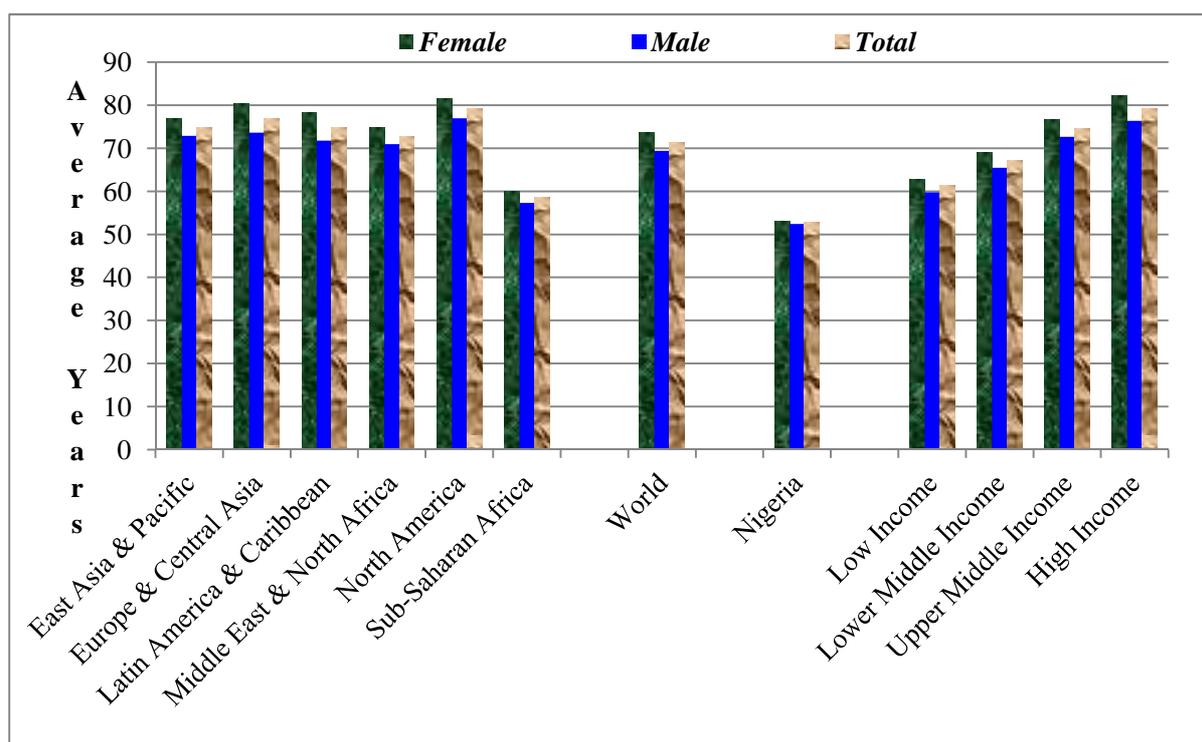
It is easy to infer from the analysis above that maternal mortality rate recorded impressive reduction between 2000 and 2015. However, when the absolute number of maternal deaths is considered as an indicator for measuring progress in overall outreach of healthcare services, the story changes. There was a reduction in the absolute number of maternal deaths between 2000 and 2015, but the reduction is not as impressive as the rate of reduction in maternal mortality rate.

From Figure 3 above, it may not be very reasonable to compare the decline in the absolute number of maternal deaths in Nigeria between 2000 and 2015 fiscal years with the observed decline in maternal mortality rate discussed above. As at 2000, Nigeria recorded a total of 62,000 maternal deaths. The number of maternal deaths oscillated severally from that point and even reached the lowest point of 52,000 maternal deaths in 2008. However, due to a further rise from that point, available records show that Nigeria recorded a total of 58,000 maternal deaths in 2015. Therefore, taking the 2015 figure of 58,000 maternal deaths and comparing same with the 2000 figure of 62,000 maternal deaths, we observe that the absolute number of maternal death merely declined by 6.45 percent between 2000 and 2015 fiscal years.

## **2. GLOBAL TREND OF DEVELOPMENT IN HEALTH**

Globally, there has been improvement in the attention given to some previously neglected diseases. The methods adopted in achieving the improvement include mass treatment of infected persons; individual treatment and care; veterinary public health; interventions in water, sanitation and hygiene; and supportive interventions to strengthen the health systems of developing countries. Due to the various forms of interventions listed above, up to 50 countries were at the point of achieving or had achieved national elimination of at least one neglected tropical diseases (WHO, 2016). As a result of the national elimination of the neglected tropical diseases in up to 50 countries, there is general improvement in global health records. One of such improvements is found in the level of average life expectancy at birth in many countries. This has also led to improvement in the global average life expectancy at birth. The Figure below shows the current global status of average life expectancy at birth.

Figure 4: Average Life Expectancy at Birth according to Regions and Income Groups (2014)



Source: Adapted from World Bank (2016) World Development Indicators

According to Figure 4 above, average life expectancy at birth as at 2014 was high for most regions of the globe. The global average life expectancy at birth in 2014 for all genders stood at 71.45 years. Within the same year, the global average life expectancy at birth in 2014 for the female gender stood at 73.60 years, while that of male gender was 69.39 years.

On a regional basis, North American region recorded the highest level of average life expectancy at birth in 2014. In North America, average life expectancy at birth in 2014 for all genders stood at 79.24 years. In the same way, average life expectancy at birth for the female gender stood at 81.66 years, while that of the male gender was 76.94 years. Following the North American region, Europe and Central Asia recorded the second highest level of average life expectancy at birth in 2014. In this region, average life expectancy at birth in 2014 for all genders stood at 76.89 years. In the same way, average life expectancy at birth for the female gender stood at 80.38 years, while that of the male gender was 73.65 years. Latin America, East Asia and Pacific, and Middle East and North Africa recorded 74.94 years, 74.92 years, and 72.82 years respectively for average life expectancy at birth for all genders. These records made the three regions to become the third, fourth and fifth best regions respectively in terms of average life expectancy at birth. Sub-Saharan Africa is the least and poorest region in terms of average life expectancy at birth. In Sub-Saharan Africa, average life expectancy at birth in 2014 for all genders stood at 58.56 years. In the same way, average life expectancy at birth for the female gender stood at 59.91 years, while that of the male gender was 57.29 years.

On the basis of income groups, High Income Countries group recorded the highest level of average life expectancy at birth in 2014. The income group's average life expectancy at birth

in 2014 for all genders stood at 79.24 years. In the same way, average life expectancy at birth for the female gender stood at 82.26 years, while that of the male gender was 76.39 years. The Upper Middle Income Countries group recorded the second highest or second best level of average life expectancy at birth in 2014. Within the Upper Middle Income Countries, average life expectancy at birth in 2014 for all genders stood at 74.66 years. In the same way, average life expectancy at birth for the female gender in this group of countries stood at 76.78 years, while that of the male gender was 72.67 years. The Lower Middle Income group of countries directly followed the Upper Middle Income group of countries as the third group in terms of average life expectancy at birth. This income group of countries recorded 67.23 years as average life expectancy at birth for all genders. In terms of average life expectancy at birth for the female gender, this income group of countries recorded 69.06 years, while the group also recorded 65.50 years as the average life expectancy at birth for the male gender. Lastly, the low income group of countries recorded the least level of average life expectancy at birth among all the income groups. Average life expectancy at birth in 2014 for all genders in the low income group of countries stood at 61.33 years. In the same way, average life expectancy at birth for the female gender in low income countries stood at 62.94 years, while that of the male gender was 59.80 years.

From the same Figure 4 above, average life expectancy at birth is lower in Nigeria than in any of the regions or income groups presented above. Average life expectancy at birth in 2014 for all genders in Nigeria stood at 52.75 years. Disaggregating the record into the male and female genders, we observe further that average life expectancy at birth for the female gender in Nigeria stood at 53.10 years, while that of the male gender was 52.43 years.

It may not be rational to compare average life expectancy at birth in Nigeria with those of other regions of the globe that Nigeria does not belong to. Nigeria is a part of Sub-Saharan Africa (SSA) and should be able to compare with the region. Therefore, comparing Nigeria's average life expectancy at birth with that of Sub-Saharan Africa, we observe that Nigeria fell (falls) below the region's average. Average life expectancy at birth for all genders in Sub-Saharan Africa stood at 58.56 years, while that of Nigeria stood at 52.75 years. Disaggregating the data into male and female gender, we observe that average life expectancy at birth for the female gender in SSA countries stood at 59.91 years, while in Nigeria, average life expectancy at birth for the female gender stood at 53.10 years. In the same way, average life expectancy at birth for the male gender in SSA countries stood at 57.29 years, whereas average life expectancy at birth for the male gender in Nigeria stood at 52.43 years.

It may not also be fair to compare average life expectancy at birth in Nigeria with those of other income groups that Nigeria does not belong to. Nigeria was previously grouped among the Low Income Countries until 2014, when the per capita income of the country moved up and Nigeria was ranked among other Lower Middle Income Countries by the World Bank. Following the upward movement, it is safe to observe that the facts presented in Figure 4 above represent 2014 fiscals, the same year that Nigeria got the status of a Lower Middle Income Country. This means that it is good to measure Nigeria's progress with respect to the income group that it belongs. Comparing Nigeria's average life expectancy at birth with that of the Lower Middle Income group of countries, we observe that Nigeria ranks below the

group. Average life expectancy at birth for all genders in the Lower Middle Income group of countries stood at 67.23 years, while that of Nigeria stood at 52.75 years. Disaggregating the data into male and female gender, we observe that average life expectancy at birth for the female gender in the Lower Middle Income Countries stood at 69.06 years, while in Nigeria, average life expectancy at birth for the female gender stood at 53.10 years. In the same way, average life expectancy at birth for the male gender in Lower Middle Income Countries stood at 65.50 years, whereas average life expectancy at birth for the male gender in Nigeria stood at 52.43 years.

Incidentally, even when comparison of Nigeria's average life expectancy at birth is done with respect to that of Low Income Countries, we still observe that Nigeria ranks below the group's average. Average life expectancy at birth for all genders in Low Income Countries stood at 61.33 years, while that of Nigeria stood at 52.75 years. Disaggregating the data into male and female gender, we observe that average life expectancy at birth for the female gender in Low Income Countries stood at 62.94 years, while in Nigeria, average life expectancy at birth for the female gender stood at 53.10 years. In the same way, average life expectancy at birth for the male gender in Low Income Countries stood at 59.80 years, whereas average life expectancy at birth for the male gender in Nigeria stood at 52.43 years.

It is important to take a quick summary of all the facts presented in Figure 4 above. The first aspect of the summary is that globally, female gender seems to live longer than male gender. The facts presented in Figure 4 above shows that female gender lives longer than the male gender in all the income groups and all the regions of the globe. Another important summary is that average life expectancy at birth in Nigeria is lower than the global average life expectancy at birth. Average life expectancy at birth in Nigeria is lower than average life expectancy at birth in Lower Middle Income Countries (which Nigeria is among). It is pitiable that average life expectancy at birth in Nigeria is even lower than average life expectancy at birth in Low Income Countries (which Nigeria is no longer among). The same is applicable when average life expectancy at birth in Nigeria is compared with that of Sub-Saharan Africa. Average life expectancy at birth in Nigeria is lower than average life expectancy at birth in Sub-Saharan African Countries (which Nigeria is among).

Comparatively, average life expectancy at birth for all genders in Nigeria is 5.81 years less than average life expectancy at birth in Sub-Saharan African Countries. When disaggregated according to gender, we observe that average life expectancy at birth for the female gender in Nigeria is 6.81 years less than that of female gender in Sub-Saharan Africa. On the other hand, average life expectancy at birth for the male gender in Nigeria is 4.86 years less than that of male gender in Sub-Saharan Africa.

In the same way, average life expectancy at birth for all genders in Nigeria is 14.48 years less than average life expectancy at birth in Lower Middle Income Countries. Disaggregating the data into genders, we observe that average life expectancy at birth for the female gender in Nigeria is 15.96 years less than that of female gender in Lower Middle Income Countries. On the other hand, average life expectancy at birth for the male gender in Nigeria is 13.07 years less than that of male gender in Lower Middle Income Countries.

Although Nigeria is no longer part of the Low Income Countries, yet we observe that average life expectancy at birth for all genders in Nigeria is still 8.58 years less than average life expectancy at birth in Low Income Countries. Disaggregating the data into genders, we further observe that average life expectancy at birth for the female gender in Nigeria is 9.84 years less than that of female gender in Low Income Countries. On the other hand, average life expectancy at birth for the male gender in Nigeria is 7.37 years less than that of male gender in Low Income Countries.

Globally, average life expectancy at birth in Nigeria has not performed well in the community of developing and developed countries of the globe. The average life expectancy at birth for all genders in Nigeria is 18.70 years less than the global average life expectancy at birth. When disaggregated according to gender, we observe further that average life expectancy at birth for the female gender in Nigeria is 20.50 years less than the global average life expectancy at birth for the female gender. On the other hand, average life expectancy at birth for the male gender in Nigeria is 16.96 years less than that of male gender on the global scene.

**Table 1: Ranking of Countries according to their Average Life Expectancy at Birth (2014)**

Ranks	MALE		FEMALE		TOTAL	
	Countries	Avg. Years	Countries	Avg. Years	Countries	Avg. Years
1	Hong Kong	81.20	Hong Kong	86.90	Hong Kong	83.98
2	Switzerland	80.80	Japan	86.83	Japan	83.59
3	Liechtenstein	80.70	Spain	86.10	Spain	83.08
4	Iceland	80.50	France	85.60	Switzerland	82.85
5	Japan	80.50	Korea, Rep.	85.48	Italy	82.69
6	Luxembourg	80.50	Italy	85.20	Singapore	82.65
7	Singapore	80.50	Switzerland	85.00	France	82.37
8	Australia	80.30	Singapore	84.90	Liechtenstein	82.26
9	Israel	80.30	Bermuda	84.69	Australia	82.25
10	Italy	80.30	Chile	84.49	Luxembourg	82.21
	<b>World</b>	<b>69.39</b>	<b>World</b>	<b>73.60</b>	<b>World</b>	<b>71.45</b>
	<b>SSA</b>	<b>57.29</b>	<b>SSA</b>	<b>59.91</b>	<b>SSA</b>	<b>58.56</b>
193	Nigeria	52.43	Angola	53.81	Nigeria	52.75
194	Angola	50.80	Nigeria	53.10	Angola	52.27

*Source: Adapted from World Bank (2016) World Development Indicators*

From Table 1 above, average life expectancy at birth for the male gender in Hong Kong is considered the highest in the world. Hong Kong also ranks the best when the average life expectancy at birth for the female gender is being considered, as well as when the average life expectancy at birth for all genders is considered. Majority of the countries that make the list of the first ten countries in the ranking of countries based on their average life expectancy at birth are in the developed countries.

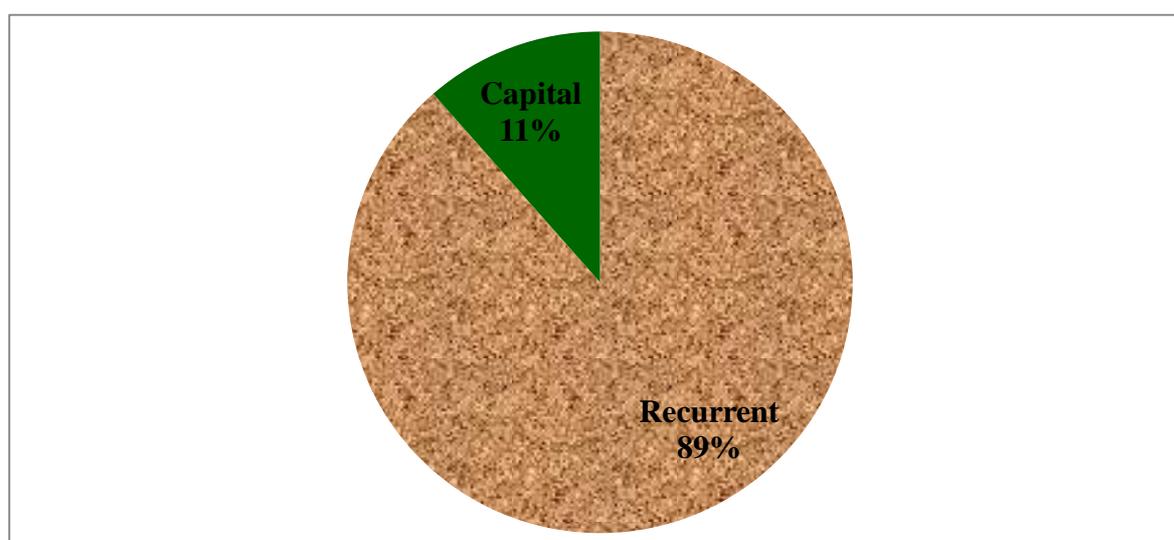
Out of a list of 200 countries that are ranked according to their 2014 average life expectancy at birth, Nigeria ranked 193<sup>rd</sup> while Angola is ranked 194<sup>th</sup> when average life expectancy at birth for the male gender is considered. However, Nigeria and Angola exchanged their positions for the average life expectancy at birth for the female gender. For average life expectancy at birth for the female gender, Nigeria ranked 194<sup>th</sup> out of 200 countries just after Angola which is ranked 193<sup>rd</sup> out of 200 countries. However, considering average life expectancy at birth for all genders, Nigeria ranked 193<sup>rd</sup> out of 200 countries, and is directly followed by Angola which is ranked 194<sup>th</sup> out of 200 countries. Based on the ranking, average life expectancy at birth in Nigeria for all genders is merely better than those of countries like Angola, Cote d'Ivoire, Chad, Sierra Leone, Swaziland, Lesotho, and Central African Republic respectively in their order of ranking. In the same way, average life expectancy at birth in Nigeria for the male gender is only better than those of Angola, Chad, Central African Republic, Cote d'Ivoire, Sierra Leone, Lesotho, and Swaziland respectively. On the other hand, average life expectancy at birth in Nigeria for the female gender is only better than those of Cote d'Ivoire, Chad, Sierra Leone, Central African Republic, Lesotho, and Swaziland respectively.

### 3. FEDERAL GOVERNMENT ALLOCATION TO HEALTH SECTOR IN NIGERIA

#### 3.1 The 2016 Allocation

The 2016 budget of the Federal Government of Nigeria allocates the total sum of ₦250.063 billion to the health sector. This amount represents only about 4.13 percent of the entire budget of ₦6.061 trillion by the Federal Government of Nigeria in 2016. Interestingly, this amount also represents a decline compared to the ₦259.752 billion (5.78 percent of total budget) allocated to the health sector in 2015 budget, out of a total federal budget of ₦4.493 billion.

*Figure 5: Proportional Allocation of Health Sector Budget in 2016 to Recurrent and Capital Expenditures*



*Source: BOF (2016) FGN Approved Budget 2016*

Disaggregating the entire budget allocation of the Federal Government of Nigeria to the health sector, we observe that the sum of ₦221.413 billion out of the total budget of ₦250.063 billion goes to recurrent expenditures. As shown in Figure 5 above, this amount represents 89 percent of the total allocation of the Federal Government of Nigeria to the health sector. This leaves only the sum of ₦28.650 billion out of the total budget of ₦250.063 billion for capital expenditures in the health sector.

Disaggregating the health sector budget allocation further, we also observe that the sum of ₦221.413 billion allocated to recurrent expenditures in the health sector represents about 8.37 percent of the sum of ₦2.646 trillion allocated to all non-debt recurrent expenditures in the 2016 budget of the Federal Government of Nigeria. On the other hand, we also observe that the sum of ₦28.650 billion allocated to capital expenditures in the health sector represents about 1.80 percent of the sum of ₦1.588 trillion allocated to all capital expenditures in the 2016 budget of the Federal Government of Nigeria. We have earlier observed that the total sum of ₦250.063 billion allocated to the health sector represents only about 4.13 percent of the entire budget of ₦6.061 trillion by the Federal Government of Nigeria in 2016. This proportion is nowhere near the 15% benchmark set by the Abuja Declaration for government allocation to the health sector.

It is interesting to observe that the health sector budget does not reflect the epidemiological realities in the Nigeria of 2016 and the capital needs of the sector. First of all, the budget allocates only 1.8 percent of all capital expenditures to health sector capital projects, whereas total allocation to the health sector represents about 4.13 percent of the entire budget of the Federal Government in 2016 fiscal year. This means that much of what makes up the health sector allocation goes to recurrent (payment of salaries and overhead). Nigeria's health workers-to-population ratio is still very low relative to other member countries of the United Nations. It therefore does not seem rational that the Federal Government of Nigeria prepares the greater proportion of the 2016 budget allocation to the health sector just to service this small number of health workers that are available. Of the overall recurrent budget of ₦221.4bn, ₦217.4billion is for personnel whilst overheads take ₦3.9 billion. Thus, personnel expenditure takes up 87.4 percent of the overall health budget whilst overheads are a paltry 1.6 percent.

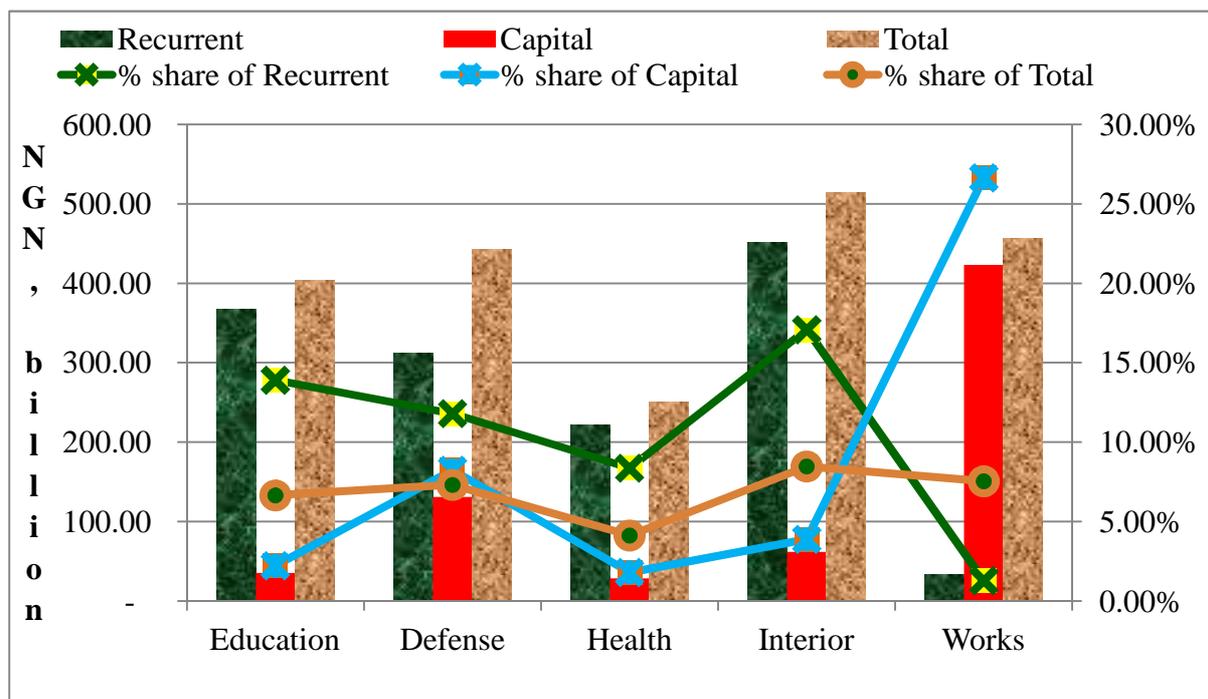
Secondly, given the gradual exit of most of the donors in the health sector, it is expected that Federal Government's allocation to the health sector will reflect the consciousness of gradual exit of these donors. This implies making additional fiscal commitment in order to fill the gaps that would have been created by the gradual exit of the donors. For example, a 4-year gradual exit of donor agencies from assisting in the health sector implies 25 percent annual withdrawal of funds. The implication is that the Federal Government should be able to calculate the value of the subsidies, financial assistance, and technical assistance given by the donor agencies. Using the value, the 2016 budget allocation to the health sector should represent an addition of 25 percent of the generated value of all the donor agencies' assistance given in 2015 to Nigeria's health sector through the Federal Government.

Thirdly, there is a general increase in the 2016 budget of the Federal Government of Nigeria from the 2015 budget. Precisely, the 2016 budget of the Federal Government of Nigeria represents an increase of 34.88 percent from the sum approved for 2015 budget of the Federal Government. It is therefore rational to expect that the 2016 budget allocation of the Federal Government to the health sector should at least reflect a similar increase. Rather than an increase, the total allocation to the health sector in the 2016 budget of the Federal Government represents a decline of about -3.73 percent from the total allocation to the health sector in the 2015 budget of the Federal Government.

### 3.2 Comparison with Other Sectors

It is a common phenomenon that the fiscal policy of any administration reveals the priorities of the administration and the policy focus of same administration. Sectoral allocations in the 2016 budget of the Federal Government present some issues of concern to any analytical mind. Figure 6 below presents a graphical view of the sectoral allocations of the 2016 budget of the Federal Government of Nigeria.

Figure 6: Comparison of Sectoral Allocations in the 2016 FGN Budget



Source: BOF (2016) FGN Approved Budget 2016

From Figure 6 above, we observe that among the five sectors presented above in the Figure, health sector receives the least of sectoral allocations. Total allocation to the health sector, which amounts to ₦250.06 billion, merely represents 4.13 percent of the total budget of the Federal Government in the 2016 fiscal year. The case of health sector allocation in 2016 will hardly compare with the total allocation that goes to the Ministry of Interior, which receives the highest amount of ₦513.66 billion. This amount allocated to the Ministry of Interior represents 8.48 percent of the total budget of the Federal Government in 2016 fiscal year. Following the Ministry of Interior from a close range is the infrastructural sector (Housing, Works and Powers sectors). The infrastructural sector receives a total allocation of ₦456.94

billion. The total allocation to the infrastructural sector represents about 7.54 percent of FGN total budget in 2016 fiscal year. The third highest sectoral allocation goes to the Defence sector. The Federal Ministry of Defence receives a total allocation of ₦443.08 billion in the 2016 budget of the Federal Government of Nigeria. This amount represents about 7.31 percent of the total budget of the Federal Government in 2016 fiscal year. Coming to the social services group of sectors, the Federal Government allocation to education sector exceeds that of health sector. In the 2016 budget of the Federal Government of Nigeria, education sector receives a total allocation of ₦403.17 billion in the 2016 budget of the Federal Government of Nigeria. This amount represents about 6.8 percent of the total budget of the Federal Government in 2016 fiscal year.

Looking at the capital expenditures component of the sectoral allocation, we observe that among the five sectors presented in Figure 6 above, health sector receives the least of sectoral allocations. Capital expenditures allocation to the health sector stands at ₦28.65 billion, which represents only 1.8 percent of the entire capital budget envelope of the Federal Government in 2016 fiscal year (i.e. ₦1,587.60 billion). This proportion of capital expenditures budget will hardly compare with the capital expenditures allocation that goes to the infrastructural sector (Housing, Works and Powers sectors). The infrastructural sector receives capital expenditures allocation of ₦422.96 billion. The allocation represents about 26.64 percent of FGN capital expenditures budget in 2016 fiscal year. The second highest sectoral allocation in capital expenditures component of FGN budget goes to the Defence sector. The Federal Ministry of Defence receives total capital expenditures allocation of ₦130.86 billion in the 2016 budget of the Federal Government of Nigeria. This amount represents about 8.24 percent of the entire capital expenditures envelope of the Federal Government budget in 2016 fiscal year. The third highest sectoral allocation in capital expenditures component of FGN budget in 2016 goes to the Ministry of Interior. The Ministry receives the sum of ₦61.71 billion, representing about 3.89 percent of capital budget envelope of the Federal Government in 2016 fiscal year. Education sector is the fourth sector among the five sectors included in Figure 6 above. The sector receives a total capital expenditures allocation of ₦35.43 billion in the 2016 budget of the Federal Government of Nigeria, which represents about 2.23 percent of overall capital expenditures of the budget envelope of the Federal Government in 2016 fiscal year.

The recurrent expenditures component of the sectoral allocation is not any better. Health sector allocation can only compare favourably with the infrastructures sector (Works, Housing and Power).

Comparing health and defence in the 2016 budget of the Federal Government of Nigeria presents some serious issues of concern. First of all, the total allocation to health sector stands at ₦250.06 billion, which represents 4.13 percent of FGN total budget, while the total allocation to the defence sector stands at ₦443.08 billion representing 7.31 percent of the total budget of the Federal Government in 2016. Secondly, the recurrent expenditures allocation to health sector stands at ₦221.41 billion, which represents 8.37 percent of FGN non-debt recurrent expenditure in 2016 budget, while the recurrent expenditures allocation to the defence sector stands at ₦312.21 billion representing 11.80 percent of FGN non-debt

recurrent expenditure in 2016 budget. Thirdly, the capital expenditures allocation to health sector stands at ₦28.65 billion, which represents 1.80 percent of FGN capital expenditures envelope in 2016 budget, while the capital expenditures allocation to the defence sector stands at ₦130.86 billion representing 8.24 percent of FGN capital expenditures envelope in 2016 budget.

Looking at all the scenarios and comparisons made above, one can argue that the policy focus of the current administration prioritises security matters. Security issues are very important in any economy that will grow. Most investors will not be persuaded to invest in an atmosphere of chaos and insecurity. However, in 2015, about 17,031 Nigerian lives were lost to all manner of violence. Out of this number, about 54.39 percent of the lost lives (i.e. 9,264 lost lives) were attributed to Boko Haram and military operations. The total number of lost lives (i.e. 17,031 lost lives) represents a decline of 24.45 percent in the incidence of violent deaths in 2015 from the total number of 22,544 lives lost in 2014 (Nigeria Watch, 2015).

On the other hand, on an annual basis, Nigeria records about 100 million cases of malaria diseases leading to over 300,000 deaths per year. In addition, another 215,000 lives are lost to HIV/AIDS per year in Nigeria (Dada and Oguntola, 2015). The implication is that even in the years that insecurity is considered to be very high, the number of fatalities recorded as a result of violence, insecurity and bad infrastructures only account for less than 10 percent of the number of deaths attributable to malaria alone. It is therefore rational to find out what informs the current administration's focus on insecurity without commensurate interest in the health of the people, especially in a country where only one type of disease kills more than 10 times the number of violent deaths recorded in the country in any particular year.

### 3.3 Health Sector Allocations over the Years

It is equally important to review the extent to which the Federal Government of Nigeria has allocated resources to the health sector over the years. Table 2 below shows the amounts allocated to the health sector between 2010 and 2016. The figure equally shows the proportions of health sector budget in the overall budget of the Federal Government of Nigeria within the same period.

*Table 2: Trend of FG Allocation to Health Sector as % of FG Total Budget*

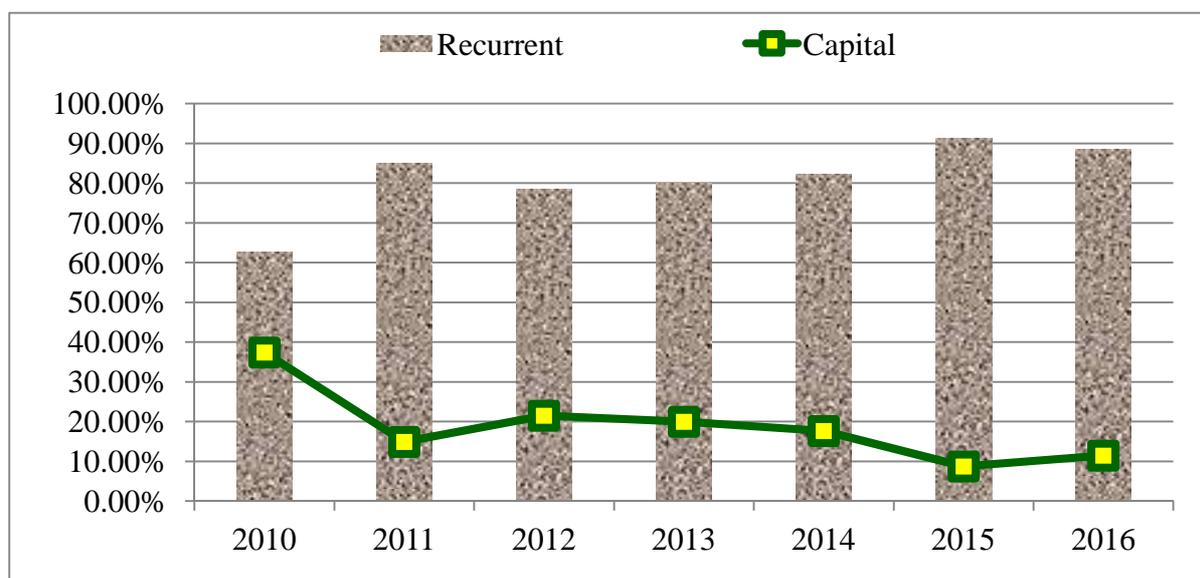
Year	Total Budget (N' Billion/Trillion)	Health Allocation (N' Billion)	As % of Total Budget	As 15% of Total (N' Billion)	Variance from 15% Benchmark (N' Billion)
2010	4,427,184,596,534	164,914,939,155	3.7	664,077,689,480	499,162,750,325
2011	4,484,736,648,992	257,870,810,310	5.7	672,710,497,349	414,839,687,039
2012	4,648,849,156,932	284,967,358,038	6.0	697,327,373,540	412,360,015,502
2013	4,987,220,425,601	282,501,464,455	5.7	738,690,600,000	458,871,046,070
2014	4,695,190,000,000	264,461,210,950	5.63	704,278,500,000	439,817,289,050
2015	4,493,363,957,158	259,751,742,847	5.78	674,004,593,574	414,252,850,727
2016	6,060,677,358,227	250,062,891,075	4.13	909,101,603,734	659,038,712,659

**Source:** *Approved Budgets - Budget Office of the Federation*

From Table 2 above, we observe that total allocation to the health sector by the Federal Government of Nigeria started from N164.9billion in 2010. The allocation started increasing gradually from 2011 and 2012. The increase in fiscal allocation to the health sector moved from 3.7 percent of the budget in 2010 to 5.7 percent in 2011 and then 6 percent in 2012. However, it fell back to N282.5billion in 2013 which represents 5.7 percent of the overall budget. In 2014, it declined again to 5.63percent of the overall budget whilst rising again to 5.78percent of the overall budget in 2015. Finally, it declined in 2016 to 4.13 percent of the overall budget. Essentially, the health budget figures and percentages have been undulating and oscillating without a pattern and consistency. It is worrisome to observe that total budget has continued to increase over the years, yet the allocation to health sector has continued to decline steadily since 2013. It has been observed earlier that the ₦250.063 billion allocated to the health sector in the 2016 budget of the Federal Government of Nigeria represents a decline of about -3.73 percent from the ₦259.752 billion allocated to the same health sector in 2015 budget of the Federal Government of Nigeria.

It is important to consider how the amount is distributed between recurrent and capital expenditure components. Figure 7 below shows how the total amounts allocated to health sector are shared between recurrent and capital expenditures.

*Figure 7: Trends of Recurrent and Capital Expenditures Allocation to Health Sector in FG Budget*



**Source:** BOF (various years) FGN Approved Budget for 2010 – 2016

It is not enough to worry only about the amount allocated to the health sector over the years. It is equally important to examine the proportions of distribution of the amount between recurrent and capital expenditure components. Figure 7 above shows that the least proportion of recurrent expenditures of the health sector between 2010 and 2016 fiscal years was observed in 2010 when recurrent expenditures accounted for about 62.62 percent of total allocation to the sector. At that point, capital expenditures accounted for about 37.38 percent of the entire budget of health sector. This fiscal year equally accounted for the highest

proportion of capital expenditures in the overall health sector budget between 2010 and 2016 fiscal years.

The proportion of recurrent expenditures continued to move rapidly up and slightly down until it reached the peak of 91.27 percent in 2015, when capital expenditures only accounted for a meagre 8.73 percent of total health sector budget. There was a little improvement in the proportional allocation to capital expenditures component of health sector budget in 2016 fiscal budget. Capital expenditures accounted for about 11.46 percent of total health sector budget in 2016 – an improvement from the 8.73 percent recorded in 2015.

It should be noted that the current trend in health sector budget is not sustainable to improve health outcomes. Nigeria's health sector still suffers a lot of deficiency in infrastructure. It is therefore not rational to allocate some meagre amounts of money to the sector in the face of such infrastructural deficits. It is a common occurrence that in many public health facilities (primary, secondary and tertiary alike), basic equipments for health and allied services are either non-existent or in moribund state. It is so bad that even where there is enough qualified health personnel, patients still get unsatisfactory services due to the absence of basic health equipment. It is worrisome that many private health facilities in Nigeria can afford to acquire and maintain many of such health equipments, while the public health facilities cannot afford to acquire or maintain one. It therefore implies that the government has not shown very high level of commitment to the health and wellbeing of the citizens through health sector budgets.

Interestingly, the 2016 budget of the Federal Government of Nigeria reveals that the health needs of over 182 million Nigerians should be catered for with only ₦28.65 billion in capital expenditures budgeted for the health sector, whereas State House Medical Centre alone receives an allocation of ₦2.825 billion for capital projects in the same 2016 budget. The amount budgeted for capital projects at the State House Medical Centre alone is about 10 percent of the amount budgeted for capital projects in all the 128 Health Facilities, Ministry, Boards, Institutes, Teaching Hospitals, and Agencies.

It is equally interesting to observe that the State House Medical Centre is accessible as a health facility to only the Presidency. This means that less than 0.0001 percent of Nigeria's population receives more attention in health budgeting than the other 182 million Nigerians. Little or no wonder why Nigeria cannot even compare with low income countries, not to mention other lower-middle income countries in terms of average life expectancy at birth. The statistical figure presented when comparing Nigeria's average life expectancy at birth with the average life expectancy at birth of Sub-Saharan Africa is very discouraging. "The Giant of Africa" as regularly referred to cannot even measure up with low income countries in terms of most of the health indicators. This makes it difficult to compare Nigeria with the health outcomes of other lower-middle income countries, where Nigeria is currently being categorised.

### **3.4 Utilisation of Allocated Funds**

Beyond the low level of proportion of capital budget in total health sector budget, it is very important to find out the level of implementation of the capital budget. This will help to

reveal necessary steps that should be taken by civil society organisations in monitoring the budget. Table 3 below shows the level of capital projects implementation between 2010 and 2015.

**Table 3: Health Capital Budget Allocation, Releases, Cash Backed and Utilisation**

Year	Approved Capital Health Budget (N'bn)	Released Health Capital Budget (N'bn)	Cash Backed Health Capital Budget (N'bn)	Utilised Sum of the Health Capital Budget (N'bn)	Utilised as a Percentage of Approved Budget	Utilised as a Percentage of Cash Backed Sum
2010	53,066	33,570	33,562	17,745	33.44	52.87
2011	55,415	38,785	38,716	32,165	58.04	83.08
2012	60,920	45,001	37,171	33,682	55.29	90.61
2013	60,047	28,838	28,838	19,109	31.82	66.26
2014	49,517	20,472	20,472	18,688	37.74	91.29
2015	22,676	16,445	16,445	12,214	53.86	74.27
<b>Total</b>	<b>301,641</b>	<b>183,111</b>	<b>175,204</b>	<b>133,603</b>	<b>Average for 6 years: 45.03</b>	<b>Average for 6 years: 76.40</b>

**Source:** Budget Implementation Reports - Budget Office of the Federation

There is a wide margin between budgeted capital expenditures and actual capital expenditures in the health sector between 2010 and 2015 as shown in Table 3 above. The percentage of approved capital budgeted utilised in 2010 was a paltry 33.44 percent; in 2011, it rose to 58.04 percent. In 2012, it declined to 55.29 percent whilst further declining to 31.82 percent in 2013. In 2014, it rose to 37.74 percent and further rose to 53.86 percent in 2015. For the six years, it averaged 45.03 percent. Again, this is an undulating movement without pattern and rhyme and shows the lack of absorptive capacity by the Federal Ministry of Health. This development raises a fundamental poser; why insist on increased allocations to the health sector when the FMOH finds it difficult to fully utilise the paltry allocations it currently receives? The answer to this poser may be predicated on the answer to another poser; what are the factors informing this poor absorptive capacity of the FMOH? The answers may not be unrelated to the late approval of budgets, haphazard and late release of sums appropriated for capital expenses, tardiness of officials of the FMOH, capacity deficits in the FMOH, etc.

Should the previous ratio of actual capital expenditures to budgeted capital expenditures be sustained in 2016, it may not be out of place to expect that no more than 50 percent of the allocation may actually be spent on capital projects in the health sector in 2016. This is especially true as most of the assumptions upon which the 2016 revenue projections were predicated have proved unrealistic and unattainable. Usually, whenever there is a decline in projected revenues of the government, recurrent expenditure budgets are implemented to the letter, while the capital expenditures are made to pay for the deficit. Going by that trend, it is safe to assume that about 50 percent of the current year capital projects in the health sector will be implemented.

### **3.5 The Health Budget had no Underlying Medium Term Sector Strategy**

The 2016 budget of the FMoH was not underpinned by a Medium Term Sector Strategy which should have conferred it with the following benefits:

- ❖ Articulate medium-term (three years) goals and objectives against the background of the overall goals of high level national policies, international standards and the attainment of the Sustainable Development Goals;
- ❖ Identify and document the key initiatives (that is, projects and programmes) that will be embarked upon to achieve the goals and objectives;
- ❖ Cost the identified key initiatives in a clear and transparent manner;
- ❖ Phase implementation of the identified initiatives over the medium-term;
- ❖ Define the expected outcomes of the identified initiatives in clear measurable terms; and
- ❖ Link expected outcomes to their objectives and goals.

### **3.6 No Provision for the Basic Health Care Provision Fund**

The 2016 health budget ignored the provisions of the National Health Act which mandates the provision of not less than 1 percent of the Consolidated Revenue Fund to the Basic Health Care Provision Fund. Since this is the law, it was incumbent on the fiscal authorities on the prompting of the Federal Ministry of Health to reflect the fact of the provisions of the law because a law takes effect from the date it is assented to by the President. The 2016 experience of leaving out the Basic Health Care Provision Fund is inexcusable and is clearly a violation of the law. It needs to be noted that what the law stated is not less than 1 percent of the Consolidated Revenue Fund which is the minimum floor. It could therefore be more than 1 percent.

The implication of the foregoing is that MNCH and related services (using the minimum floor of 1 percent) lost good sums of money. With a total Consolidated Revenue Fund of N3.855trillion in 2016, 1 percent amounts to N38.555bn which should have been remitted to the Basic Health Care Provision Fund. Of this sum, 45% percent of the Basic Health Care Provision Fund would have gone to the National Primary Health Care Development Agency which would have used it for a number of programmes including MNCH. This would amount to N17.350billion in 2016. Also, the 50 percent of the Basic Health Care Provision Fund going to basic minimum package of health services to citizens through the National Health Insurance Scheme would have impacted on MNCH.

### **3.6 Donor Funds were not Identified in the Budget**

The 2016 federal health budget did not take cognisance of the contribution of Development Partners through grants and other support mechanisms. It is possible that in calculating the resources voted to the sector, the authorities may have taken cognisance of the development aid, but this is not clear on the face of the budget. Admittedly, there are provisions for

counterpart funding, especially in the Service Wide Votes, but the percentages and overall sums are not clear. This is faulty as it does not portray a true picture of the level of funding available for health interventions. This is not the practice in other African countries and runs against the standard Nigerian Appropriation Bill clause that:

*All Accounting Officers of Ministries, Parastatals and Departments of Government who control heads of expenditure shall upon the coming into effect of this Bill furnish the National Assembly on a quarterly basis with detailed information of all foreign and or domestic assistance received from any agency, person or organisation in any form whatsoever.*

If this is the law, all grants sums that are due for a draw down within the year should have been declared and incorporated into the budget. The fact that these contributions are not captured may lead to double counting in terms of FGN paying for services and facilities already funded by donors. It may also lead to corruption by MDA officials. This may also be responsible for the poor absorptive capacity of the Federal Ministry of Health to the extent that it focuses more on using donor funds whilst neglecting the official FGN funds.

#### **4. LESSONS FOR IMPROVED HEALTH FUNDING**

Owing to the glut in global oil prices, Nigerian governments' revenues have continued to decline since the second half of 2014 fiscal year. It therefore implies that the Federal Government should adopt a high level of fiscal discipline in order to achieve her development goals. It is interesting to observe that in the 2016 fiscal year, the sum of ₦35.67 billion was proposed in the budget for health sector capital projects. However, during approval, the amount was reduced to only ₦28.65 billion, whereas the ₦217.42 billion proposed for personnel costs was increased to ₦217.47 billion before approval. In a similar way, the sum of ₦4.30 billion was proposed for overhead cost in the same 2016 budget, whereas only the sum of ₦3.94 billion was approved for the same overhead cost. The little proportion of health sector budget in the total budget of the Federal Government of Nigeria was even reduced during appropriation. The sum of ₦257.38 billion was proposed as total budget of the health sector in 2016 FGN budget. Only the sum of ₦250.06 billion was approved as the total budget of the health sector in 2016 FGN budget.

Without any significant alteration in the proposed recurrent expenditures of the health sector, the National Assembly approved an amount that is significantly lower than what was proposed. The reduction is mainly attributed to the reduction in the capital expenditure component of the proposed budget of the health sector. The reduction does not reflect corrections that are based on the recommendations of civil society organisations or other stakeholders that analysed the proposed budget and submitted their reports to the National Assembly. Certain line items in the recurrent expenditure component of the approved budget can still be done without, while freeing up the money meant for such line items to be used for other capital projects in the sector.

It may not be said that FGN's health sector budget reflects a need to develop the country's health sector. It may not also be said that the current year health sector budget of the FGN

reflects a country that is aware that most of the vaccines it received free through donor agencies may no longer be entirely free due to Nigeria's recent level of economic growth that moved the country from low income group to lower-middle income group of countries. These two realities are complicated by the recent decline in the country's revenue generation capacity as a result of the glut in the global oil market. Therefore, Nigeria's health sector is faced with two critical options of "looking for more funds" and or "efficient utilisation of available funds". Looking for more funds should be the right way to go. But the developmental aid component of funding is shrinking. Donor agencies are already exiting funding of Nigeria's health sector, thereby constraining the options available to the health sector. This focuses attention on domestic resource mobilisation for health and improvements in the efficiency of the utilisation of available funds.

On the basis of the foregoing, it is important to learn from the Indian experience. India exhibits similar attributes to Nigeria in terms of the contribution of the governments to total health expenditures. Just like Nigerian governments, Indian Government spends 22% – 30% of total health expenditures in India. The rest of the health expenditures are borne by the households. It should be expected that the similarity in fiscal features of the two countries should imply similarity in health outcomes. But this is not the case in reality. Indian health sector witnessed tremendous growth and improvement between 1998 and 2011 (KPMG, 2010). This did not come without feasible, measureable, specific, and time-bound health sector plan. To get to the current level of growth and improvement, Indian public sector partnered with the private sector over the period of three decades.

Therefore, effective and productive public private partnership scheme in the health sector in Nigeria can still free up some funds for the government and at the same time raise enough funds to improve on the health services in Nigeria. It is true that up to 75 percent of total health expenditures in India are borne by private sector actors, yet most of the expenditures are not just on health consumables, but more on health infrastructures. Given the level of development of Nigeria's health sector, most households pay for health consumables and health services, while in India, most households pay to become shareholders of renowned health facilities and infrastructures. Therefore, rechanneling private sector funds from health consumables to health facilities will go a long way in improving Nigeria's health sector. To be able to do so, Nigeria's public sector will need to acquire basic infrastructures that will make Nigerian households to stop providing for themselves every minute health consumable whenever they get to the health facilities. This is what improved capital expenditures can achieve. Also, the recurrent expenditure component of the sector's budget to be reviewed and all the frivolous line items expunged from the budget.

## **5. CONCLUSION**

The Federal Government of Nigeria is faced with a cash crunch. At the same time, the recent growth of the Nigerian economy with its attendant categorisation of the country among the lower-middle income countries has necessitated donor agencies to plan their exit in funding Nigeria's health sector. This means that more funds should be expended on the health sector by Nigerian governments. The 2016 approved budget of the Federal Government of Nigeria

does not reflect these realities. The total approved budget of the Federal Government of Nigeria in 2016 amounts to an increase of 34.88 percent from the 2015 approved budget of the Federal Government of Nigeria, whereas the approved budget allocation to the health sector amounts to a decline of about -3.73 percent from the approved budget allocation to the same sector in 2015. This decline does not reflect the consciousness of an increased fiscal burden on the Federal Government due to the exit of the funding agencies. More importantly, the allocation of funds to capital expenditures component of the health sector is very deficient given the level of development and improvement of the sector.

Therefore, the study recommends that the following steps should be taken:

- ❖ Increased allocation to the health sector to reach the 15 percent Abuja Declaration benchmark. The bulk of the new resources should go to capital expenditure to enhance access to equipment and health supporting infrastructure.
- ❖ The implementation of the National Health Act setting aside not less than 1 percent of the Consolidated Revenue Fund to the Basic Health Care Provisions Fund.
- ❖ Guarantee the preparation of Health Sector Medium Term Sector Strategies to inform the 2017 federal budget.
- ❖ Increasing the efficiency of health sector spending through greater value for money strategies. Ensure strict and efficient implementation of the resources allocated to the health sector.
- ❖ Public private partnership schemes in the health sector should be encouraged but made as transparent and efficient as possible. This will ensure that the areas that the public sector cannot delve into as a result of cash crunch, the private sector actors can augment and fill the funding gaps. However, necessary caution must be applied in adopting the public private partnership model of health funding in order not to price public health facilities beyond the reach of the ordinary Nigerian.
- ❖ FGN should explore innovative funding mechanisms for the health sector including compulsory universal health insurance scheme for all Nigerians.
- ❖ The FMOH should embrace civil society as a critical partner in achieving greater value for money in a bid to improve national health outcomes.
- ❖ Civil society should start the 2017 budget engagement process early enough with interventions in the MTSS, pre budget memorandum and analysis to inform the new budget of 2017.

## **REFERENCES**

Budget Office of the Federation (BOF) (2006). 'FGN 2006 approved budget'. Abuja: BOF Publications.

- Budget Office of the Federation (BOF) (2007). 'FGN 2007 approved budget'. Abuja: BOF Publications.
- Budget Office of the Federation (BOF) (2008). 'FGN 2008 approved budget'. Abuja: BOF Publications.
- Budget Office of the Federation (BOF) (2009). 'FGN 2009 approved budget'. Abuja: BOF Publications.
- Budget Office of the Federation (BOF) (2010). 'FGN 2010 approved budget'. Abuja: BOF Publications.
- Budget Office of the Federation (BOF) (2011). 'FGN 2011 approved budget'. Abuja: BOF Publications.
- Budget Office of the Federation (BOF) (2012a). 'FGN 2012 approved budget'. Abuja: BOF Publications.
- Budget Office of the Federation (BOF) (2012b). 'Quarterly budget implementation report—fourth quarter 2012'. Abuja: BOF Publications.
- Budget Office of the Federation (BOF) (2013a). 'FGN 2013 approved budget'. Abuja: BOF Publications.
- Budget Office of the Federation (BOF) (2013b). 'Quarterly budget implementation report—fourth quarter 2013'. Abuja: BOF Publications.
- Budget Office of the Federation (BOF) (2014a). 'FGN 2014 approved budget'. Abuja: BOF Publications.
- Budget Office of the Federation (BOF) (2014b). 'Quarterly budget implementation report—fourth quarter 2014'. Abuja: BOF Publications.
- Budget Office of the Federation (BOF) (2015). 'FGN 2015 approved budget'. Abuja: BOF Publications.
- Budget Office of the Federation (BOF) (2016). 'FGN 2016 approved budget'. Abuja: BOF Publications.
- Dada, T. and Oguntola, T. (2015, April) "World Malaria Day: Nigeria Ranks Highest In Death Rate – US". Leadership Newspaper, *Apr 26, 2015*.
- KPMG (2010) "Healthcare: Reaching out to the masses". Available at: [https://www.kpmg.de/docs/Healthcare\\_in\\_India.pdf](https://www.kpmg.de/docs/Healthcare_in_India.pdf)
- Nigeria Watch (2016) *Fifth Report on Violence in Nigeria 2015*. Abuja: Nigeria Stability and Reconciliation Programme Publications.

Section 8 of the 2013 Appropriation Act and section 10 of the 2014 Appropriation Act.

- Tyessi, K. and Okeke, V. (2015) "Crisis looms in Nigeria's Health Sector as Donor Partners withdraw Funds". In Leadership Newspaper, 24 November, 2015. Accessed on 27/04/2016 14:59 from: <http://leadership.ng/news/477665/crisis-looms-nigerias-health-sector-donor-partners-withdraw-funds>
- United Nations (2015) *World Economic Situation and Prospects*. New York: United Nations Publication. Accessed on 27/04/2016 14:37 from: [http://www.un.org/en/development/desa/policy/wesp/wesp\\_archive/2015wesp\\_full\\_en.pdf](http://www.un.org/en/development/desa/policy/wesp/wesp_archive/2015wesp_full_en.pdf)

World Health Organisation - WHO (2015). *Global Health Statistics*. Luxembourg: WHO Publications. Accessed on 28/04/2016 14.28: at: [http://apps.who.int/iris/bitstream/10665/170250/1/9789240694439\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/170250/1/9789240694439_eng.pdf)

World Health Organisation - WHO (2016). *World Health Statistics: Monitoring Health for the SDGs*. Luxembourg: WHO Publications. Accessed on 28/05/2016 14.28: at: [http://apps.who.int/iris/bitstream/10665/170250/1/9789240694439\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/170250/1/9789240694439_eng.pdf)