

## Policy brief

### Monitoring social investment in Africa: do spending targets help?

#### 1. Introduction

Three criteria for classifying public investment, namely, administrative, economic and functional (see figure I), are identified in the *Government Finance Statistics Manual* (International Monetary Fund, 2014). The criteria complement one other and capture investment from various dimensions with distinct analytical applications. In so doing, the spending targets in education, health and social protection will be useful in assessing the translation of political intent to resources, allowing for comparability in countries, and most importantly, assessing the relevance of spending targets in achieving the intended objectives.

Social investment refers to the economic effort made on the social development of individuals, households and communities (Cecchini and others, 2015). The use of the term “investment” is applied because the resources allocated to social issues (i.e., education, health and social protection) yield economic and social returns. Social investment consists of public or private resources that are used mainly to ensure a supply of adequate food, health care, education, housing, water and sewerage systems, or to finance demand for these, and provide monetary insurance against loss of income or assets that would risk living standards falling below an acceptable level (Martinez and Collinao, 2010).

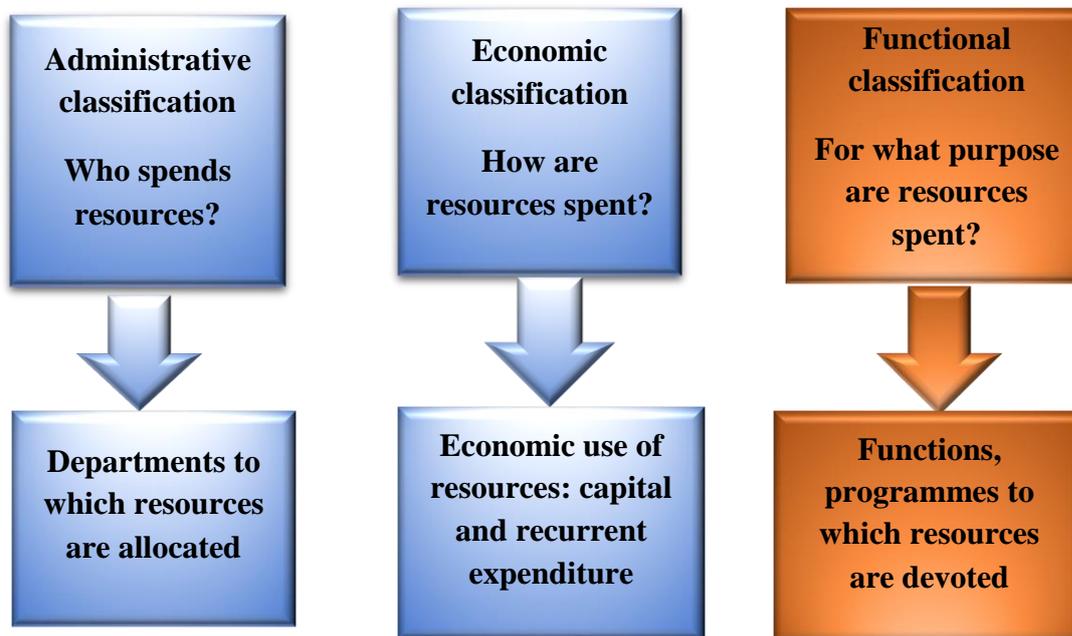
There is a level of difficulty in analysing social investment, in particular between executing the resources and who finances them. Records of social investment-related transactions tend to track only the executing entity. Systems of national accounts should, in theory, provide a clear source for that component, but Africa lacks mandatory or standardized systems with regular detailed information of source in this area. In Africa, another complication is the mix between private and public social investment in education, health and social protection. Private expenditure by households on health is approximately 50 per cent of total expenditure, and therefore public spending does not capture total health spending. Nevertheless, public social spending data that are available allow for the quantifying of specific outlays by the State, whatever their financing source, by following the procedures set out in the *Government Finance Statistics Manual*.

The present policy brief<sup>1</sup> contains an assessment of social investments in Africa, with an emphasis on Kenya and Nigeria, given that they pertain to the functional classification (see figure I) of education, health and social protection spending.

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<sup>1</sup> This is the first in a series of Social Development Policy Division policy briefs on the monitoring of social investment, based on two country studies (Kenya and Nigeria). The project will be used to present five country studies (Chad, Kenya, Mauritania, Mozambique and Nigeria).

Figure I  
Criteria for classifying social investment



Source: Adapted from Martinez and Collinao (2015).

The policy brief also provides the rationale behind the idea of spending targets, which can be grouped into three areas: attest the link between political commitment and its translation into resource target allocation; monitor the progress of spending with quantifiable targets, which lends itself to more transparency and accountability of public spending policies; and provide an indication of spending efficiency that maps resources as one of the inputs in improved social outcomes and that provides useful lessons on the role of spending targets.

## 2. Social spending in Africa

In Africa, public social spending figures, in general including education, health, social welfare, water and sanitation, employment and housing, are important in demonstrating prioritization in the budgets on social areas (Harrington and others, 2007). On average, public social spending in the Organization for Economic Cooperation and Development countries amounted to approximately 21 per cent of gross domestic product (GDP) in 2016.

Box

### Spending targets during the Millennium Development Goal era

During the period 2000–2010, the Millennium Declaration was converted into the time-bound quantitative targets of the Millennium Development Goals, which, in turn, spurred the introduction of measurable development spending and outcomes. Health spending, for example, had a target of 15 per cent of government expenditure that was set by the African Union in Abuja in 2001 (African Union, 2001) and was concomitant with the introduction of the Goals in 2000. It should be noted that the spending target was set during a specific time, namely, the HIV/AIDS pandemic (Economic Commission for Africa, 2014).

In 2005, with the completion of the mid-term review of progress in achieving the Millennium Development Goals, low-income countries, including those in Africa, were urged to mainstream the Goals into their national plans with aligned cost estimates to spur progress in achieving the social Goals (Keita and Gauci, 2017; Boko, 2014; Economic Commission for Africa, 2017). That, in turn, catalysed African Governments, between 2005 and 2009, to set social spending targets for education and social protection (see table 1), which could be used to assess the progress in achieving the outcomes (Economic Commission for Africa, 2013, 2014).

Table 1

#### Target spending for the social Millennium Development Goals

<i>Sector</i>	<i>Target</i>	<i>Frameworks</i>
Education	20 per cent of government expenditure	Education for All Fast-Track Initiative costing target of 20 per cent of government expenditure has been signed by more than 25 African countries.
Health	15 per cent of government expenditure	Abuja Declaration on HIV/AIDS, Tuberculosis, and other Related Infectious Diseases. Health spending also has a target of 15 per cent of government expenditure set by the African Union in Abuja in 2001 (African Union, 2001).
Social protection	4.5 per cent of GDP	International Labour Organization 2008 study based on the African Union Social Policy Framework for Africa (African Union, 2008).

Source: Bastagli (2015).

While total public expenditure in Africa is comparable to global figures, at approximately 30 per cent, the allocation to social expenditure in Africa (for countries with data available) is higher than in developed countries (see table 2). There is a substantial variation throughout countries in the subregion. Nigeria, for example, spent close to 20 per cent of consolidated average government expenditure on health, education, skills training and social protection during the period 2006–2016. In Kenya, social spending had decreased from 39.7 per cent of government expenditure in 2012–2013 to 25.18 per cent in 2016–2017 (Obona, 2017; Nafula, 2017).

Table 2  
**Social expenditure as a proportion of public expenditure by subregion, 2010**  
 (Per cent)

<i>Subregion</i>	<i>Number of countries with data available</i>	<i>Social expenditure as a proportion of total public expenditure</i>
North Africa	4	36.1
East Africa	5	32
Central Africa	1	7.5
West Africa	3	19.5
Southern Africa	9	34

*Source:* International Food Policy Research Institute, Statistics on Public Expenditures for Economic Development (SPEED) website.

## 2.1 Spending targets for education

In the education sector, a specified spending target has been signed by 60 per cent of African countries, excluding those in North Africa. The Education for All Fast-Track Initiative was an agreement urging governments to increase their budgetary allocation to education to 20 per cent of total public expenditure.

A review of African countries' educational spending against the spending target does provide information on the adherence to a political commitment and provides useful data on the pertinence of setting spending targets.

On average, the spending performance of African countries remained close to the target set during the period 1995-2012 (see figure II). That average varied throughout Africa. Countries such as Botswana, Eswatini, Kenya, Lesotho, Namibia and Tunisia, for example, spent more than the 20 per cent target in education between 2000 and 2012.<sup>2</sup> Overall, there was an annual 12.5 increase in education public allocation during the period 2000–2011, which might have contributed to increasing primary enrolment figures, from approximately 50 per cent in 1999 to 80 per cent in 2013, and to significant increases in children's enrolment in primary schools, from 62 million in 1990 to 149 million in 2012 (Economic Commission for Africa, 2014, 2015).

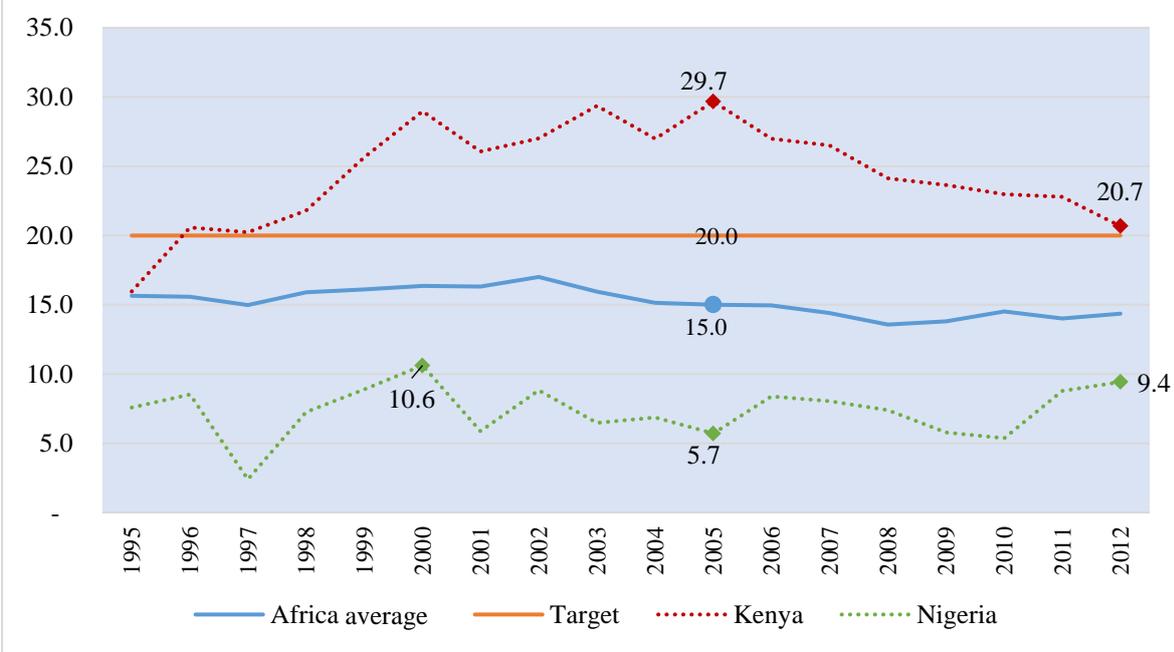
While average spending in Nigeria remained far from the target, education spending increased to 12 per cent of government expenditure during the period 2006–2016, which is less than the 27 per cent proposed by the National Assembly (Obona, 2017).

An important observation is that there has been no discernible variation, on average, in education spending post-2009 when the spending target was set. This raises an important point: if the progress achieved in education outcomes apparently did not require an adherence to the

<sup>2</sup> International Food Policy Research Institute, Statistics on Public Expenditures for Economic Development (SPEED) website. Available at [www.ifpri.org/publication/statistics-public-expenditures-economic-development-speed](http://www.ifpri.org/publication/statistics-public-expenditures-economic-development-speed).

spending target, and lower spending was considered sufficient and associated with improved outcomes, it brings into question the relevance of the education spending target.

Figure II  
**Education expenditure as a proportion of government expenditure 1995–2012**  
 (Per cent)



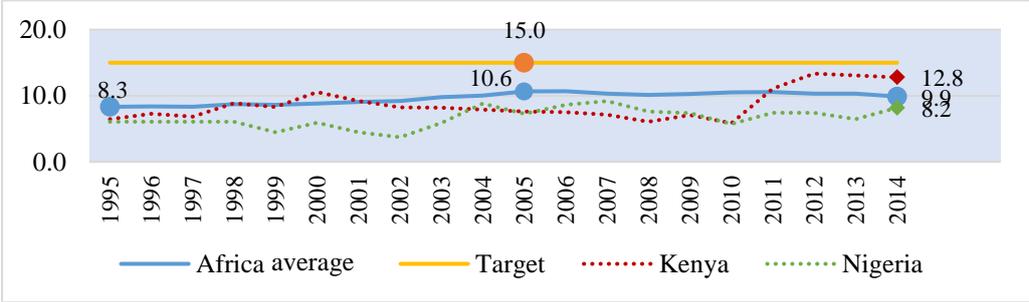
Source: Authors’ computations based on data from the World Bank 2016 world development indicators.

**2.2 Spending targets for health**

Two conclusions could be drawn from the spending review of African countries (see figure III). First, the average health spending in Africa has historically been far below the target than education spending. On average, health spending in Africa increased by 1.6 per cent, from 9.1 per cent of government expenditure in 2001 to 10.7 per cent in 2012. Second, several African countries increased their health spending from 2002 to 2004, including Malawi, Rwanda, Sierra Leone and the United Republic of Tanzania, by approximately 3 to 4 percentage points of government expenditure.<sup>3</sup> Health spending in Nigeria increased sharply from 2002, while it did the same in Kenya after 2010. An interesting observation is that in Kenya, health spending accounted for 37.8 per cent of total development expenditure on social services during the period 2015–2016. The growth in the sector was attributable mainly to developments in social infrastructure, possibly reflecting proximate rather than ultimate objectives (Nafula, 2017).

<sup>3</sup> World Bank 2016 world development indicators.

Figure III  
**Africa health expenditure as a proportion of government expenditure, 1995–2014**  
 (Per cent)



Source: Authors’ computations based on data from the World Bank 2016 world development indicators.

Public health spending does present a specific issue of relevance. The cost-sharing scheme with households and private spending constitutes a large part of health outlays. The public spending review of African countries is limited because of the private expenditure on health goods and services. Between 2000 and 2009, in 40 African countries with data available, household spending on health was more than 50 per cent of total health spending, (Sambo and others, 2013). Indeed, out-of-pocket payments increased in nearly all African countries, from \$15 per capita in 1995 to \$38 in 2014 (World Bank and others, 2016). In Lesotho, for example, between 1 and 3 per cent of households faced catastrophic expenditure in 2001 because 40 per cent of their monthly income was spent on health (Akinkugbe and others, 2012). The evidence on large private health spending outlays and the negative effects on poverty indicates the need to increase public spending on health.

**2.3 Spending on social protection**

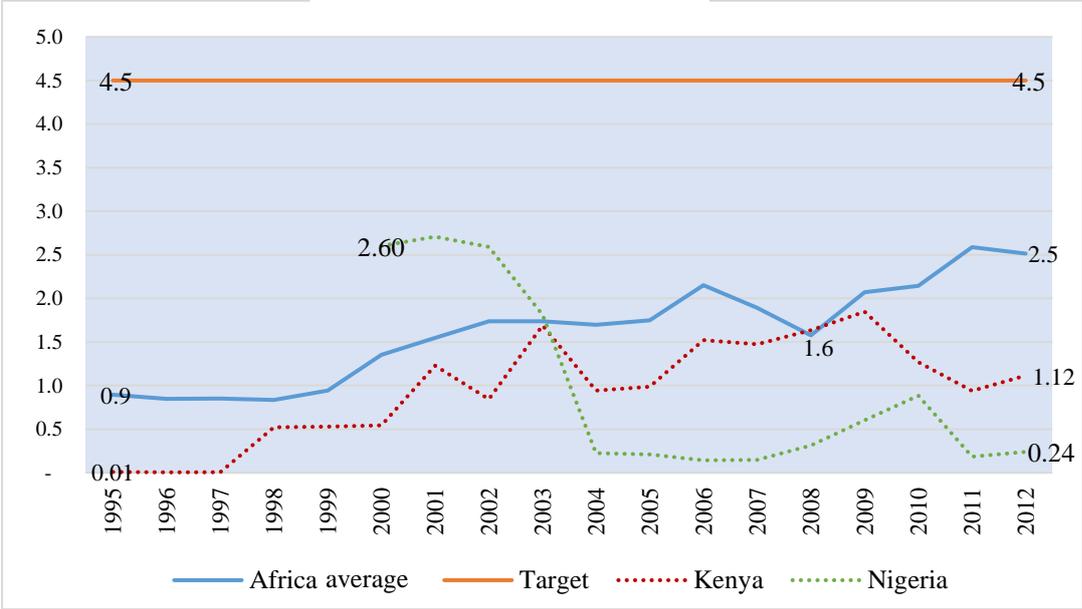
Social protection has emerged as a global objective in the current Sustainable Development Goals. In Africa, the spending target on social protection arises from an International Labour Organization (ILO) study on the Social Policy Framework for Africa, endorsed in Windhoek in 2008. The African Union ministers agreed on the provision of a minimum package of social protection that included basic health care and specific programmes on older persons, among others. The cost estimate for social protection as set out in the Framework was carried out by ILO, which estimated an average of 4.5 per cent of GDP (International Labour Organization, 2008).

The varying definition and which social areas are prioritized by African countries make a review of social protection spending against expenditure targets challenging. Given that the country-specific identification of vulnerable groups and the proportion covered by social protection programmes varies considerably, comparative spending reviews are limited. In Africa, however, there is an overall tendency for the early and later part of a person’s life cycle to be the focus (see table 3). The productive phase in a life cycle, involving a focus on employment and unemployment, is absent. In addition, there is the possibility of “double-counting” for health as health expenditure and specific features of education spending, such as other social expenditure, are made. There is some increase in the average overall social protection spending in post-2008 Africa, with a higher financial outlay for social protection that increased from 1.6 per cent of GDP in 2008 to 2.5 per cent on average in 2012 (see figure IV).<sup>2</sup>

An important observation can be made on the review of African countries’ social protection spending. The post-2008 period showed a general increase in social protection spending. In Kenya, for example, the increase in social protection spending picked up after 2012, from 6 billion shillings in 2014-2015 to 13.7 billion in 2015-2016, and was expected to increase marginally, to 14.4 billion in 2016-2017 (Nafula, 2017). The sharp increase in social protection spending observed after 2008 reflects political intent converted into increased expenditure, yet the targets appear to be more indicative rather than commitments.

An interesting observation is that, in Nigeria, the implementation of the social protection strategy in 2016 refocused policy attention and consequent budgetary allocation, identifying a country-specific vulnerable group and reducing vulnerability through more skilled workers and job creation (Obona, 2017).<sup>4</sup>

Figure IV  
**Africa social protection expenditure as a proportion of GDP, 1995–2012**  
 (Per cent)



Source: Authors’ computations based on data from the International Food Policy Research Institute, Statistics on Public Expenditures for Economic Development (SPEED) website.

<sup>4</sup> There are six areas in the Nigeria social protection strategy: the Teach Nigeria programme, the Youth Empowerment programme, the Conditional Cash Transfer programme, the Home-Grown School Feeding programme, the Free Education for Tertiary Institutions programme and the Micro-Credit Scheme programme.

Table 3

**Proportion of population covered by social protection floors/systems in selected global regions**

(Per cent)

<i>Global Regions</i>	<i>Children</i>	<i>Mothers with newborns</i>	<i>Retirees</i>	<i>Unemployed</i>	<i>Persons with disability</i>	<i>Vulnerable (social assistance)</i>
Africa, excluding North Africa	13.1	n/a	22.7	3	n/a	7
North Africa	n/a	69.1	n/a	n/a	n/a	n/a
East Asia	10.8	22.5	77.3	19.5	n/a	32.5
Latin America	56	53.5	70.8	12.2	59.4	39.2

*Source:* United Nations calculations based on International Labour Organization estimates using country data compiled through the latter's 2017 social security inquiry.

Many lessons have been learned from the setting of the Millennium Development Goal spending targets in education, health and social protection for African countries. The performance of the spending by African States against the targets shows that benchmarking had the effect of galvanizing political intent and its transformation into increased resource allocation in social protection. In all three areas reviewed, spending did increase, although gaps were observed from the intended targets. The acknowledgement of universalism in education has in part, driven a better performance of attaining the spending targets. Indeed, universalism in health has not had the same depth of political commitment, which, to some extent, explains the larger gap from the spending target, and private spending on health might explain the gap from the health spending target.

Social protection spending on targeted vulnerable groups remains small, although increasing. Coverage is slight, and the inclusion of essential health services under social protection "crowds out" the expected universality of primary health provision.

The link between universalism and targeting is the possibility of ensuring that no one is left behind.

The estimate of spending targets for the Sustainable Development Goals has its advantages. The translation of political intent to spending targets has shown that there is an increase in both expenditure and outcomes. The lessons learned from the review of African countries' expenditure on education, health and social protection in relation to the previous Millennium Development Goal-related spending targets are two-fold. First, the mainstreaming of the Millennium Development Goals into national plans led to social-related cost estimates that had positive effects on accelerating outcomes and, in some instances, on spending. Second, African countries are being urged to undertake that same process of mainstreaming the 2030 Agenda for Sustainable Development into national plans. This assists in costing estimates and indicative spending benchmarks towards achieving the Sustainable Development Goals.

This exercise is useful in setting national priorities and their relative costs and replicates the anchoring of the Millennium Development Goals into national plans with a positive acceleration of outcomes observed.

### **3. Policy recommendations**

- National spending targets should be implemented, not in so far as setting thresholds of expenditure, but as indications of political intent. While evidence has shown that increased spending on education, health and social protection is associated with improved social outcomes, more research on efficiency of spending and outcomes is required.
- African countries should ensure that universal application in social areas that has converted political intent to commitment and performance is much closer to the target set.
- African Governments should ensure that intersectoral resource allocation in education and health translates into social outcomes rather than intermediary outputs for better monitoring of social investment.
- The definition of social protection should be harmonized in African countries, using the African Union’s Social Policy Framework for Africa as a base, to avoid the double counting of health and education spending and improve the monitoring of social investment in African countries.
- African Governments should compute the spending targets for the next set of goals (i.e., the Sustainable Development Goals), which has the benefit of galvanizing political intent. The universal nature of the 2030 Agenda of “leaving no one behind” requires the estimation of more inclusive policies within the spending targets.

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