The Global Economic Crisis and Healthcare Delivery in Nigeria: An Empirical Analysis: Herbert C. Edeh, PhD & Elias Chukwuemeka Ngwu

ABSTRACT

The article evaluates the impact of the recent global economic crisis on healthcare delivery in Nigeria. This is set against the backdrop of the general concern expressed at the on-set of the crisis that it would have grave consequences on the health sector not only in the less developed countries but even in the OECD countries as well. We predicated our analysis on the theoretical tradition of the Marxian political economy paradigm which views global economic crisis such as was recently experienced not as an isolated event but as part and parcel of the generalized/ cyclical capitalist crisis. We used tables and graphs to empirically measure the actual impact of the crisis vis-à-vis the earlier projections. We found that the crisis impacted adversely on healthcare delivery in Nigeria, particularly on the HIV/AIDS sub-sector but that the impact was not as grave as had been predicted. The study noted that the impact was mitigated in part by the limited duration of the crisis, but also by the continued intervention of some overseas development agencies. Hence, we recommend that African leaders must learn to mobilize their vast human and natural resources to play the global competitive game rather than continue to rely on external sources to cushion the effects of future crises on their populace.

Key words: Economic crisis, healthcare delivery, Africa, Nigeria.

Introduction

The global economic crisis that swept through most of the inhabited earth beginning from late 2007 may have ebbed somewhat but its negative impacts are still very much felt, particularly in the less developed regions of the world. The crisis, which 'was triggered by the credit crunch within the US sub-prime mortgage market' (Ajakaiye and Fakiyesi, 2009:1) raised serious concerns over its likely impact on healthcare delivery not just in the less developed countries but even also in the Organization for Economic Cooperation and Development (OECD) countries as well. It was projected that the crisis would have serious negative impact on healthcare, particularly in the less

Herbert C. Edeh, PhD is with the Department of Political Science, University of Nigeria, Nsukka
E-mail: herbertedeh@yahoo.com herbert.edeh@unn.edu.ng **Tel. 2348064003039**
&
Elias Chukwuemeka Ngwu is with the Department of Political Science, University of Nigeria, Nsukka
E-mail: eliasngwu@yahoo.com. elias.ngwu@unn.edu.ng **Tel. +2348038052242; +2348126864546**

developed countries, through a number of channels. These include reduction in household incomes, fall in remittances from overseas, reduction in national health budgets, reduction in Official Development Assistance (ODA), reduction in health-related overseas private assistance (say from foundations), and fall in commodity prices.

Overall, it was predicted that the impact of the economic meltdown on healthcare delivery would be grave. The World Bank, for instance, predicted that a decline in GDP of one or more points increases average infant mortality by 7.4 per 1000 births for girls and to 1.5 per 1000 births for boys. It was also feared that the falling commodity prices occasioned by the crisis would affect the capacity of many African countries, particularly the oil exporters, to fund social services, including health, and that increased poverty would result in worse nutritional status, which would in turn affect the quality of health.

These concerns were reinforced by the fact that overall healthcare financing in Sub-Saharan Africa has been constrained, not only in terms of the volume of funds available, but also by the fragility of the underlying governance structures that have not adequately addressed the efficiency of resource allocation and use (Musau, 2010: 1). With particular reference to Nigeria, Adekanye, et al (2009:7) pointed out that "the government had warned concerning the 2009 budget, that the budget is not going to be workable or implementable and that means budget cuts across all the sectors including health".

This paper empirically investigates the actual impact of the global economic crisis on the funding streams for healthcare delivery in Nigeria. This is with a view to matching the actual experience with the earlier projections. The study explained the crisis as a moment in the general cyclical crisis that inheres in the nature of the capitalist economy. It therefore urges African leaders to take steps to shield their populace from the vagaries of this inherently unstable system rather than abandon the task to external actors.

Theoretical Perspective

Scholars, commentators, and sundry analysts have explained the recent global economic crisis in various ways. Such explanations include: the inability of home-owners to make their mortgage payments, poor judgment by the borrower and/or lender, speculation and overbuilding during the boom period, risky mortgage products, high personal and corporate debt levels, financial innovation that distributed and concealed default risks, central bank policies, and regulation (Stiglitz, 2008). Avgouleas (2008) enumerated the causes of the crisis as: breakdown in underwriting standards for sub-prime mortgages; flaws in credit rating agencies' assessments of sub-prime Residential Mortgage Backed Securities (RMBS) and other complex structured credit products especially Collaterized Debt Obligations (CDOs) and other Asset-Backed Securities (ABS); risk management weaknesses at some large US and European financial institutions; and regulatory policies, including capital and disclosure requirements that failed to mitigate risk management weaknesses (See Adamu, 2009: 5-6).

While these explanations are not irrelevant for the discussion of the recent global crisis, as explanations they are inadequate for the understanding of the complexities of the crisis. For a proper understanding of the nature and character of the crisis therefore, we

hinge our analysis on a theoretical perspective which views crises like the recent one as part of the cyclical crisis inherent in the nature of the global capitalist economy. In this vein, Eskor Toyo (2002: 13) had stated thus:

> A capitalist economy is inherently a very unstable system. It reproduces inflationary tendencies, depressions, balance of payments disequilibria, stock market booms and crashes, strikes and contradictory changes of government policies by its very nature.

According to this perspective, a mature capitalist economy goes through cycles of medium term prosperity and depression (or expansion and contraction), each cycle of prosperity followed by a depression lasting three to nine years. During the prosperity, sales, investment, employment, profits, other incomes and prices all accelerate upwards. The investment climate is attractive and business optimism prevails. This prosperity, however, is soon followed by a depression and after a time business optimism is followed by pessimism. Investment is soon arrested. Then investment, sales, employment, profits and other incomes go down. In the cause of capitalist history, business cycles have occurred regularly with a duration of three to nine years, and while each cycle has its own peculiarities (and even trigger factors), there are things that are common to all the cycles so that it is possible to have a general description of them (Toyo, 2002: 26-27).

Basically, the capitalist economy is crisis-prone because of the decision making autonomy enjoyed by capitalist firms and because these firms engage in the unilateral pursuit of profit maximization which implies their non-subjection to a social plan executed with an over-riding social discipline. There is thus a divorce between private drive and social requirements. For this basic reason, incompatibilities between one part of the system and related parts tend to build up to the stage where the system cannot sustain them and they constitute a crisis. Accordingly, the system generates crying absurdities as a normal mode of reproduction (Toyo, 2002: 25-26).

Essentially therefore, the 2007 to 2009 crisis represents an existential crisis of the global capitalist system, which is often called its general crisis and which manifests in balance of payments crises and stock market crashes. These cycles are usually propagated to the developing countries in the neo-colonial capitalist world through trade, international capital movements, the general price level and the exchange rate as well as balance of payments. The crisis was therefore more a rule than an exception.

Global Economic Crisis and Healthcare Delivery: The Problematique

In response to concerns expressed by Member States of the World Health Organization (WHO), the Director-General had convened a high-level consultation before the opening of the Executive Board's 124th session on the impact of the global economic and financial crisis on global health. The objectives were:

(a) To build awareness of the ways in which an economic downturn may affect health spending, health services, health-seeking behaviour, and health outcomes;
(b) To make the case for sustaining investments in health; and

(c) To identify actions – including monitoring of early warning signs – that can help to mitigate the negative impact of economic downturns (WHO, 2009).

The high-powered consultation identified a number of pathways through which a recession in rich economies can affect other countries. According to the report export growth may decline – this is already reflected in a major fall in commodity prices; foreign direct investment is likely to be reduced; sudden and dramatic falls in exchange rates are possible, although not inevitable; access to capital may become more difficult as interest rates and risk premiums rise; remittances from abroad may fall; and, most critically for the poorest countries, aid from donors may be significantly delayed or reduced (WHO, 2009: 7).

The report stated further that total health spending in countries that have been affected by an economic downturn tends to fall, but not consistently (WHO, 2009: 7). Reductions in total expenditure will have an impact on the composition of health spending. Also, many of the human consequences of recession are often hidden. For example, unemployment may erode women's growing economic independence, which will have its own health consequences. Similarly, coping strategies may exacerbate vulnerability (through, for example, increased exposure to HIV). Reduced spending has impacts on health and education, and ultimately on the well-being of families and the development of the community as a whole (WHO, 2009: 7).

The consultation suggested five areas where action at global, regional and country levels –with support from WHO – will help to ensure that the health sector emerges from the crisis in good condition. These are:

- Leadership
- Monitoring and analysis
- Pro-poor and pro-health public spending
- Policies for the health sector
- New ways of doing business in international health (WHO, 2009: 7).

Also, in a report prepared by the African Center for Gender and Social Development (ACGS) titled the 'African Perspectives of the Global Economic and Financial Crisis, including the Impact on Health', it stated that the biggest concern is that the crisis may degenerate into a *social development crisis* on the continent as the recession deepens. It was also feared that it would have major effects on people's enjoyment of their human rights. The report predicted further that the crisis was likely to disrupt and in some instances reverse development gains, compromising progress toward the Millennium Development Goals (the MDGs), especially those aiming to reduce poverty, hunger, maternal and child mortality, and ensuring 'decent work for all' (ACGS, 2010: 1).

According to the report, the predicted impact of the crisis on health outcomes is grim. Increasing unemployment and poverty will lead to less food security and quality of nutrition, leading to growing health inequities. It pointed out that some African governments were already cutting back on already insufficient HIV treatment and care programmes because of the crisis. Child malnutrition and infant mortality might increase

by 200,000 and 400,000 additional deaths in 2009 (UNICEF, 2009). Women, children, the poor, and minority groups, were expected to suffer disproportionately from the health impacts of the crisis (ACGS, 2010: 3).

The report identified two major channels through which the global financial and economic crisis will impact on social development including the health sector in Africa. These, it classified as the supply side effects and the demand side effects. The supply-side effects are those that directly affect the operating environment for the health sector and other social development services by affecting the supply of health and social services. The global financial and economic crisis is affecting the health sector directly by affecting the supply of health services, manifested mainly through government cutbacks in expenditure as a result of reduced revenues due to falling exports and as a result of potential reduction in ODA. This reduction in financing translates into reduced investment in health and availability of health services. The crisis thus threatens to reverse the gains that Africa had made on social development.

The financial and economic crisis through exchange rate devaluation is making it more expensive for countries to obtain imported equipment and drugs. Essential life medicines may become either unavailable or unaffordable (WHO, 2009). Depreciation of currencies in the region will increase domestic prices of food in countries that are net importers of food and reduce access to food by vulnerable groups thereby affecting the nutrition and health outcomes of many.

The Demand side effects directly affect the health sector by affecting the household characteristics and its ability to demand health services. The global financial and economic crisis is affecting availability of income of the general population through loss of employment, and reduced remittances. Overall reduction in income will result in reduced consumption of health services due to lack of resources to pay to access health services, and reduced consumption of other basic goods such as education, food, and nutrition security, that are essential for positive health outcomes.

It noted that Africa has already been facing challenges in securing healthcare for its population, and that the crisis would only make the situation worse. African countries are constrained in their capacity to finance health as evidenced by the low levels of public sector health spending in many countries. The major challenges affecting public sector health financing include low domestic resource mobilization capacity, limited fiscal space, and constrained economic growth. Clearly, a significant gap remains between the current and needed financing for achieving the health MDGs. The financial crisis is likely to worsen the availability of domestic public resources that are allocated. Yet public resources are important for addressing health inequities (ACGS, 2010: 5).

The report observed that although some progress has been made in the past decade on some aspects of health that include measles vaccination, access to improved water supply, and reductions in HIV prevalence rates in some countries, very limited headway has been made on achieving the health MDG. Available data suggest very little improvements in reducing infant, child and maternal mortality in many African countries. The financial crisis can aggravate the situation resulting in reduced progress towards

achieving the goals.

Similarly, although Maternal Mortality Rate (MMR) has been reduced from 250 per 100, 000 live births in 1990 to 160 per 100 000 live births in 2005 in Northern Africa, MMR remains unacceptably high in Sub Saharan Africa. The sub-region has an average MMR of 900 per 100 000 live births in 2005 (UN, 2008). Thirteen countries in Africa still have an MMR of more than 1000 per 100 000 live births. MDG 5 is thus lagging the furthest behind. The reduction in budgets for health that is likely to result from the financial crisis will make this goal even more difficult to realize. Chete (2009: 1) made the additional point that aside undermining progress toward the MDGs, the effects of the financial crisis and economic slowdown may also put at risk the gains to date in relation to these goals.

Hecker (2009:10) pointed out that the global response to the HIV & AIDS epidemic has been unparalleled; between 2007 and 2008 funding increased from US$ 11.3 billion to US$ 13.7 billion globally. He however predicted that the global economic crisis would have dire consequences for HIV & AIDS funding, particularly in sub-Saharan Africa, which has the highest levels of HIV & AIDS infection in the world, with approximately 25 million people infected. This amounts to more than 60% of global infections. Across the board, HIV & AIDS programmes in Africa are extensively funded by Western donors.

Similarly, a report released in June 2009 by UNAIDS and the World Bank projected that the global economic crisis would significantly disrupt HIV & AIDS prevention and treatment programmes over the course of 2009. The report specifically warned of the consequences of funding cuts. Amongst these consequences are increased mortality and morbidity, unplanned interruptions and curtailed access to treatment, increased risk of HIV transmission, higher future financial costs, an increased burden on health systems and a reversal of economic and social development gains. According to the report, a survey of countries representing approximately 60% of people on Antiretrovirals (ARVs) globally projected that by the end of 2009, treatment programmes in more than a third of these countries would be directly affected by budget shortfalls, due to the downturn.

In the same vein, Kirigia, et al. (2001) stated that there is ample evidence from Asia and Latin America showing that economic and financial crises resulted in cuts in expenditures on health, lower utilization of health services, and deterioration of child and maternal nutrition and health outcomes. Owing to reductions in the size and growth of GDP, unless protected, the per capita spending on health and other social sectors is likely to decrease. For instance, evidence from previous Latin American economic crises shows that governments tend to decrease social expenditures during times of economic recession. Also, Indonesian experience indicates that the health budget tends to be especially vulnerable to reductions during times of financial and economic crisis. The proportion of government health ministry budgets going to salaries (already high in many countries) tends to increase as capital spending and other operating expenditures decline. Reductions in maintenance, medicines or other operating expenditures related to disease

surveillance or supervision are likely to have a more damaging and immediate effect on quality and quantity of health service delivery (Kirigia et al, 2011: 2].

According to them, decreased real per capita household spending on health, coupled with increased costs of treatment and low coverage of prepaid health schemes will lower household demand for private sector health services, with demand switching to the public sector. Because the public sector is already facing reduced funding, it may not be adequately equipped to absorb any surges in demand, and the result may be a worsening in quality of care. In most countries of the African Region, publicly-funded health services were already overstretched long before the onset of the crisis. During periods of economic crisis, poorer households are likely to suffer the most as they are unable to re-adjust and cushion their expenditures, often forcing a decline in demand for health services. As economic activity slows down and unemployment rises, both labour and non-labour incomes tend to decline, resulting in reduced real per capita household spending on health and other social services. They pointed to the Argentinean experience as evidence that without targeted pro-poor interventions or safety nets, the poor are disproportionately affected in terms of utilization of health services

In addition, poor households are also forced to reduce food quantity (caloric intake) and quality (dietary diversity), resulting in weight loss and severe malnutrition. Children who experience short-term nutritional deprivations can suffer long-lasting effects including retarded growth, lower cognitive and learning abilities, lower educational attainment, and, consequently, lower earnings in adulthood. The report, maintained that although donor countries and international financial institutions had made strong commitments to help, past banking crises have led to sharp declines in ODA, including health development assistance.

Similarly, it has been argued that there has been an increase in ODA flows to Africa since the Monterrey Consensus was adopted in 2002, increasing from $21 billion in 2002 to $38.7 billion in 2007. However, the prognosis is that donors will likely reduce ODA flows to the region in response to the financial crisis. While there is no evidence yet that donors plan to reduce flows, history and econometric evidence suggest that ODA flows tend to be pro-cyclical and so it is reasonable to expect a decline. Furthermore, pressures to recapitalize the banking sector and provide support for ailing industries may force developed countries to cut down on ODA flows to Africa (Chete, 2009: 15-16). Thus, there is a real danger that funding for health development in the African Region might be adversely affected by the ongoing global financial crisis and thereby compromise any on-going national and international efforts in many countries to realize the Millennium Development Goals (Kirigia et al, 2011: 20).

In Nigeria, although ODA represents about 2% of total budgetary allocations, it nonetheless represents a major factor in the drive towards achieving the MDGs at the lower tiers of government, as well as in the development of good governance at state and local government levels. In some cases, there are strong commitments by several donor agencies and their countries towards attainment of the MDGs, but there are still many hurdles to overcome. Efforts are still required or needed to be expanded on various areas

of the MDGs, particularly on reducing child mortality, prevention and treatment of HIV/AIDS among other diseases, etc. In other areas such as maternal and newborn mortality, there has been little change; to halve the population that has no access to adequate sanitation or essential medicine, etc (Kirigia et al, 2011: 21).

Focusing on the impact of the global economic crisis on the Nigerian economy and its implication for the social service sector, Ajakaiye and Fakiyesi (2009: 14) stated that the consequences of the global financial crisis on growth and development in Nigeria are enormous and widespread. The first point of impact, according to them, is through the drop in the price of oil. This is followed by the fall in the share price of the stock market. The combined effect of these two led to the depreciation of the naira exchange rate. Further worsening the situation is the withdrawal of foreign portfolio investment (hedge funds) from the Nigerian market. As of January 2009, foreign portfolio investors have withdrawn some US$15 billion from the country's capital markets. Such massive withdrawals compound the crisis of confidence, which has further complicated the capital market recovery process. The transmission of these impacts to the real and financial sector will surely hamper growth and development of the Nigerian economy. Lower growth would also mean a slowdown in the fight against poverty. Worsening poverty removes further the prospects of attaining the internationally agreed targets for halving the number of the poor within the framework of the MDGs by the year 2015. They stated that in the face of dwindling foreign exchange earnings, the CBN had had to evolve management tactics that indirectly supported the naira, and whose overall impact was less budgetary allocation at all tiers of government to growth and development-enhancing programmes and high cost of importation for critical infrastructure development, as in the power and health sectors.

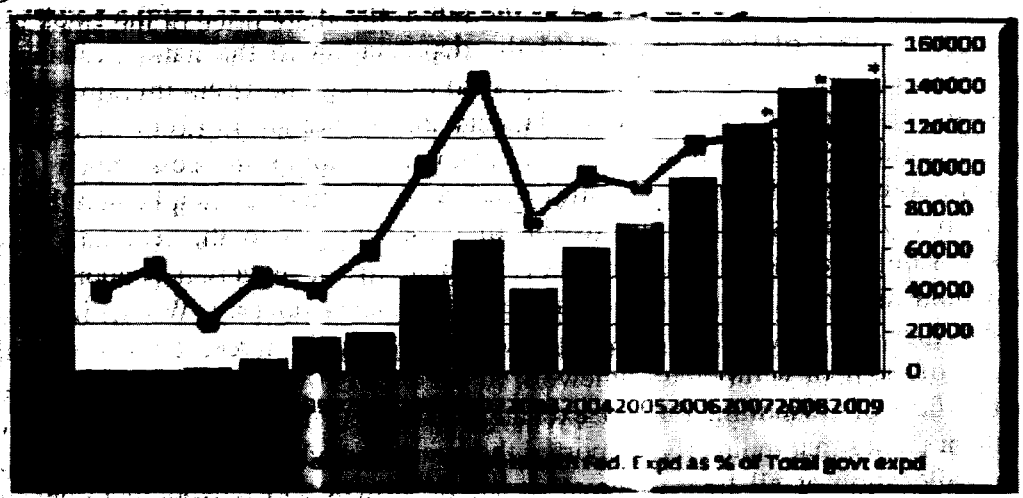
Giving this unsettling scenario, and also taking into cognizance that there is lack of evidence about how past economic crises in the African Region affected health system funding, including effects on inputs, service outputs and health outcomes; as well as on the social determinants of health that shape people's daily lives and their differential access to money, power and resources which significantly affect health inequities both within and between countries this paper proposes to bridge this gap by examining in the next section the actual impact that the crisis has had on the funding of healthcare delivery in Nigeria in relation to the various projections.

Global Economic Crisis and Health Delivery in Nigeria: The Evidence

In the preceding section we reviewed the concerns about, and the various projections on, the probable impact of the global economic crisis on healthcare delivery in sub-sub-Saharan Africa particularly with regard to funding. Summarily, it was feared that the crisis would lead to contraction in national budgets, including budgets for health, due to fall in commodity prices, drop in individual household incomes, fall in remittances, reduction in external/donor funding, etc. In this section, we proceed to examine the evidence on ground to determine empirically how the crisis has impacted on the funding of healthcare delivery, focusing specifically on Nigeria.

In their analysis of the implication of the global economic crisis on the Nigerian economy, Ajakaiye and Fakiyesi (2009:26) stated that the share of the health sector in total expenditure between 1985 and 1999 was insignificant. Specifically, it was 1.09% in 1990. This share increased from 1999 until 2002, when it dropped. The rise picked up again, but only gradually until 2008. They however pointed out that just as in education, the share of health in total expenditure in 2009 dropped from 6% to 4.6% as is shown in Figure 1 below.

Figure 1: The Share of Health in Total Expenditure in Nigeria, 1985 - 2009



Note: * Represents estimated values.

Source: CBN (2006) cited in Ajakaiye and Fakiyesi (2009:26)

It is to be noted however that the figures for 2008 and 2009 in the table above represent estimated values. Empirically though, the evidence on ground tends to support these projections. As shown by Muanya (2009), an analysis of the 2008 and 2009 budgets show that contrary to the World Health Organisation (WHO) recommendation and the Abuja Declaration by African countries to commit 15 per cent of their budget to health, the allocation for health as a percentage of the GDP actually decreased from six per cent in 2008 to five per cent in 2009. Mitik (2009: 15) stated that the sectoral allocation to education and health in 2009 showed a 16% cut in education and 29% cut in health allocations. Similarly, the allocation to Human Immuno-Deficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) as percentage of the health budget decreased from 16 per cent in 2008 to 12 per cent in the 2009 budget (Muanya, 2009: 2).

Compounding the drop in the domestic budget for HIV/AIDS in Nigeria is the fall in offshore funding from the global 'power-houses' namely: PEPFAR and Global Fund. The US President's Emergency Plan for AIDS Relief (PEPFAR) was launched in 2003 by former US President George W. Bush to combat the global HIV & AIDS pandemic. The fund committed itself to providing US$ 15 billion over five years (2003-2008) in support of the fight against HIV & AIDS. In July 2008, PEPFAR was reauthorized with an

impressive US$ 48 billion approved for the 2009 to 2013 financial years. After assuming office, President Barack Obama announced his Global Health Initiative, which saw PEPFAR's budget extended to US$ 51 billion, but available over a six year period (7). Owing, in part, to the global economic crisis however, the fund has 'effectively been flat-lined for 2009 and 2010 with similar proposals for the following years'. Médecins Sans Frontières (MSF) said PEPFAR aims to pass on the responsibility of direct funding treatment for patients to countries whenever possible, or else to the Global Fund. It however warned that cutbacks in rich-world funding for Aids treatment could sentence millions of sufferers to death for lack of access to anti-retroviral (ARV) drugs (SAfAIDS, 28 May 2010).

On its part, the Global Fund to Fight AIDS, Tuberculosis and Malaria was established in 2002 to prevent and treat these three profound health concerns. The Global Fund collaborates with Governments, civil society, the private sector and affected communities to combat the disease. It also works closely with other bilateral and multilateral organisations to further supplement existing efforts. Since its inception, the Fund has approved US$ 15.6 billion to fund 572 programmes in 140 countries. 57% of the fund's money is channeled to sub-Saharan Africa. The Fund was however not immune to the effects of the economic crisis. As a result, it has introduced certain changes in its funding plan.

Amongst the changes to funding which had to be made was that all grants approved for funding in Round 8 would have to be decreased by 10%. Round 9 was to be postponed by six months and to be the only round in 2009. Additionally, Phase II (years 3 through 5) of existing and future grants would be decreased by 25%. The Fund required US$ 170 million to cover its 2008 programme commitments, and further faced a US$ 4 billion shortfall in meeting its goals up to 2010. In an interview on April 20, 2009, Professor Michel Kazatchkine, Head of the Global Fund, admitted that "For the first time, the demand for funds has exceeded the funds we have available." He also added that Round 10 funding will have to be suspended from 2010 to 2011 to replenish funds (Health-e, 2010).

Pledges to the Fund announced on 5 October 2010, fell short of the lowest target set by the Fund as essential to continue current treatment rates. Governments and private donors committed USD11.7 billion over three years after the Global Fund set a minimum target of USD13 billion. UNAIDS has noted that for the first time in 15 years, overall AIDS funding has not increased, even though HIV infection rates have continued to grow, with 33 million people currently estimated to be living with HIV. The Fund had hoped to raise $20 billion to significantly reduce the growth of the epidemic, including the goal to eliminate the transmission of HIV from mother to child by 2015 (Health-e, 2010).

Empirically, global funding for AIDS efforts fell flat in 2009 as a result of the economic meltdown, ending a six-year streak of annual donation increases. Overall, financial support for international HIV/AIDS assistance fell more than 1 percent to US $7.6 billion in 2009, from US$7.7 billion the previous year, according to a report from Kaiser Family Foundation and the Joint United Nations Programme on HIV/AIDS. The

report measured donations from the Group of Eight most industrialized nations, European Commission and other donor governments to low- and moderate-income countries, and noted difficulties interpreting real value as reporting cycles and currency fluctuated (Health-e, 2010).

Perhaps, the import of this seemingly marginal drop would be better appreciated if we consider that until now, financial aid increased by at least 11 percentage points annually since 2002, when the groups donated US$1.2 billion for international AIDS assistance. We need consider also that in 2008 alone, assistance jumped up 57 percent to US$7.7 billion, US$4.9 billion in 2007. So that even though the United States—the world's largest donor nation—increased its contribution by more than 11 percent to US$4.4 billion in 2009, from US$3.95 billion the year earlier, total international AIDS funding still fell approximately US$7.7 billion short of the need in 2009. Of course, the effect of this shortfall in funding is spread evenly across the aid recipient countries.

Another channel through which it was envisaged that the global economic crisis would impact on healthcare delivery in Nigeria as in many other developing countries is the contraction in GDP. More than a year into the economic recovery, growth in high-income countries remains tepid. The weak recovery has been attributed to sovereign stress in Europe, the reduction in global risk appetite, and the adoption by many governments of more sustainable fiscal policies, which, over the short term, inhibit growth. And as a result of these factors, global GDP was projected to increase by just 3.3 percent in 2010 and 2011 and 3.5 percent in 2012 (Fisher, 2009: 3). Table 1 below shows changes in GDP in the African Region. As is evident, Nigeria, like many other countries in the region, recorded a negative GDP growth change in 2009 relative to year 2008. Her GDP fell from USD 207.116 billion in 2008 to USD165.437 billion in 2009 signifying a -41.679 percentage change.

Perhaps, to fully appreciate the full import of this negative GDP growth change on the health sector in Nigeria, we need recall the projection by the World Bank that a decline in GDP of one or more points increases average infant mortality by 7.4 per 1000 births for girls and to 1.5 per 1000 births for boys (The World Bank, cited in Adekanye et al, 2009:7).

Table 1: Changes in Gross Domestic Product in the African Region (US$ billions, current prices)

Country	GDP		
	Year 2008	Year 2009	Change
Algeria	159.669	134.797	-24.872
Angola	84.945	69.708	-15.237
Benin	6.712	6.401	-0.311
Botswana	13.461	10.808	-2.653
Burkina Faso	8.116	7.780	-0.336

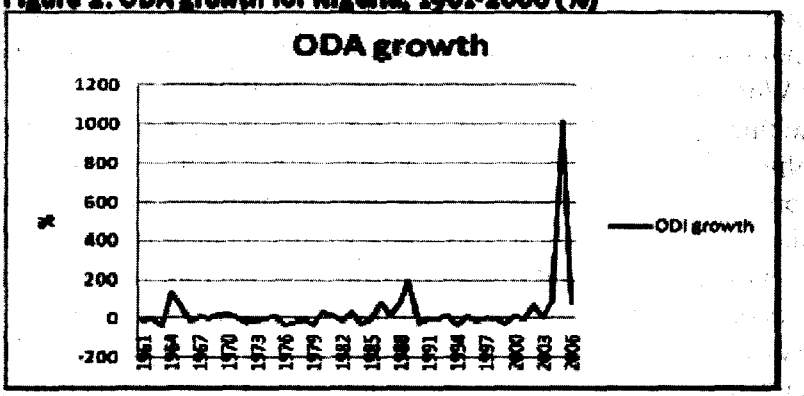
Burundi	1.097	1.410	0.313
Cameroon	23.732	21.820	-1.912
Cape Verde	1.744	1.755	0.011
Central African Republic	1.997	1.983	-0.014
Chad	8.400	6.974	-1.426
Comoros	0.532	0.525	-0.007
Democratic Republic of Congo	11.629	11.104	-0.525
Congo, Republic of	10.774	8.632	-2.142
Côte d'Ivoire	23.508	22.909	-0.599
Equatorial Guinea	18.525	11.175	-7.35
Eritrea	1.479	1.694	0.215
Ethiopia	26.393	33.920	7.527
Gabon	14.535	10.936	-3.599
Gambia, The	0.810	0.726	-0.084
Ghana	16.654	14.761	-1.893
Guinea	4.517	4.436	-0.081
Guinea-Bissau	0.461	0.438	-0.023
Kenya	29.564	30.212	0.648
Lesotho	1.618	1.624	0.006
Liberia	0.850	0.868	0.018
Madagascar	9.463	8.974	-0.489
Malawi	4.268	4.909	0.641
Mali	8.774	8.757	-0.017
Mauritania	3.161	3.241	0.08
Mauritius	8.738	9.156	0.418
Mozambique	9.897	9.654	-0.243
Namibia	8.835	9.039	0.204
Niger	5.382	5.323	-0.059
Nigeria	207.116	165.437	-41.679
Rwanda	4.459	5.011	0.552

Sao Tome and Principe	0.175	0.189	0.014
Senegal	13.350	12.610	-0.74
Seychelles	0.822	0.656	-0.166
Sierra Leone	1.953	2.064	0.111
South Africa	276.764	277.379	0.615
Swaziland	2.840	2.929	0.089
Tanzania	20.668	22.159	1.491
Togo	2.890	2.771	-0.119
Uganda	14.565	15.658	1.093
Zambia	14.654	12.293	-2.361
Zimbabwe	3.145	3.556	0.411
TOTAL	**1093.641**	**999.161**	**-94.480**

Source: IMF (2010) cited in Kirigia *et al. BMC International Health and Human Rights* 2011 11:4

Another concern expressed with respect to the impact of the global economic crisis on healthcare delivery in Nigeria is the possible reduction in the quantum of Official Development Assistance (ODA) from governments of the industrialized nations under the aegis of the OECD. Ajakaiye and Fakiyesi (2009: 6) for instance feared that most countries' budget deficits are likely to increase considerably because of the rescue packages for banks and, in some cases, the real sector, and that this could limit the developing countries' scope to receive development assistance. And even though the major donor countries had pledged to increase their ODA quotas to 0.7% of GDP, and to support achieving the MDGs by 2015, there were concerns that donors' promises would not be honoured in their entirety.

Figure 2: ODA growth for Nigeria, 1961-2006 (%)



Source: (WDI Omnibus CD-ROM 2007 edition) cited in Ajakaiye and Fakiyesi (2009: 6)

Empirically, these fears turned out to be largely unfounded though. In 2009, total net Official Development Assistance (ODA) from members of the OECD's Development Assistance Committee (DAC) actually rose slightly in real terms (+0.7%) to USD 119.6 billion, representing 0.31% of DAC members' combined Gross National Income (GNI). The net bilateral ODA to Africa was USD 27 billion, representing an increase of 3% in real terms over 2008. USD 24 billion of this aid went to sub-Saharan Africa, an increase of 5.1% over 2008. The overall expected ODA level for 2010 was estimated at USD 108 billion (Fisher, 2009: 2). This is obviously a welcome departure from the negative trends that characterized the other sources of funding for healthcare delivery in Nigeria as in other countries of the sub-Saharan Africa owing to the global economic crisis

Discussion of Findings

A number of points flow from the preceding presentations. The first is that prior to the global economic crisis, allocation to healthcare as a share of the national income in Nigeria fell far below the 2001 Abuja Declaration by African countries to commit 15 per cent of their national budget to health sector. Between 2002 and 2008, the sectoral allocation to health had oscillated between 3 and 6 per cent with the high point being in 2002, just immediately after the Abuja declaration. The crisis nonetheless resulted in a reduction in the sectoral allocation to health in relation to 2008 (the 2008 allocation was done before the crisis became pronounced). While it could be argued that the percentage drop in the allocation to the health sector in the 2009 budget is marginal in relation to 2008, it is to be noted that the drop broke a trend of upward movement that began in 2004 after a low in 2003. Also, given the contraction in the national GDP in the same period, the drop is more significant in real terms than the statistics show.

The second point to note from the above presentation is the diminution in the GDP of most countries in the African zone following the crisis. This brings into bold relief the dilemma of these countries in a global system in which they are utterly dependent on the 'prosperity from abroad' and are therefore highly vulnerable to the dynamics and the contradictions inherent in the global capitalist system. But even more

telling is the World Bank projection that a decline in GDP of one or more points increases average infant mortality by 7.4 per 1000 births for girls and to 1.5 per 1000 births for boys (The World Bank, cited in Adekanye et al, 2009:7)

The third point to note is that the global economic crisis appears to have impacted more on the HIV/AIDS sub-sector than any other social sector with global resource mobilization for the pandemic being in serious jeopardy. This is due, in large measure, to the dependence of countries of the SSA on external funding to combat the pandemic.

A fourth point is that contrary to the general expectation that the crisis would result in a drastic reduction in the quantum of Official Development Assistance (ODA) from the world's industrialized and developed nations to the less developed nations, there was in fact a marginal increase in the volume of such assistance in 2009 compared to 2008. Ordinarily, this would have constituted a piece of cheering news but for certain implications that flow from it. One such implication is the contrast between the stability in the ODA flow from the developed nations and the instability in the domestic revenue source of the recipient nations. It immediately raises concern over, for instance, how the leadership of these recipient countries, particularly in the African region would have hoped to carry on with the business of service provisioning had the global crisis persisted and the ODA eventually fizzled out? What safety nets are in place for the citizens of these nations to access in the event of a recurrence of such crisis?

Of more serious concern though is the implication of aid dependence for the recipient countries. The point here is that the primary responsibility for service provisioning in any country lies with the government of such country. Or put differently, it is the responsibility of such government to ensure that such basic services are provided. When such government fails in the discharge of this basic responsibility, or increasingly depends on other countries, or even multilateral agencies, to discharge this basic responsibility, the legitimacy of such a government is often called to question and, over time, the sovereignty of such a state is gradually eroded and eventually under-mined. Hence, the categorization of some countries as 'ungoverned territories'.

Conclusion

This paper examined the impact of the recent global economic crisis on healthcare delivery in Nigeria against the backdrop of the generalized apprehension at the on-set that the crisis would have grave consequences for healthcare delivery in Africa. Relying on data from budgetary allocation to the health sector, health-related ODA, overseas private funding, as well as allocation to other social sectors that impact on the health of the citizens, the study found that the impact of the recent global economic crisis on healthcare delivery in Nigeria cum Africa has not been as grave as was feared but that it nonetheless impacted negatively on the sector, particularly the HIV/AIDS sub-sector.

Anchoring the analysis on the theoretical prism of Marxian political economy, the study argued that the impact of the crisis on health delivery in Nigeria was mitigated not by any ingenious policy response on the part of Nigerian policy makers but rather by the limited duration of the crisis, which allowed for the continued inflow of public and

private overseas development assistance to the health sector even while the crisis lasted. Essentially, the crisis once more exposed the vulnerability of African states in the face of a generalized capitalist crisis which is bound to recur sooner or latter. It therefore calls for concerted efforts on the part of Nigerian policy makers to articulate appropriate policy responses in the event of future occurrence.

REFERENCES

Abdul, A. (2009). 'The Effects of Global Financial Crisis on Nigerian Economy.' www.rrojasdatabank.info/crisisdb/onnigeria09.pdf

ACGS (2009). 'African Perspectives of the Global Economic and Financial Crisis, Including the Impact on Health.' Bing a Report prepared by Prepared by the African Center for Gender and Social Development (ACGS)

Adekanye, T. O. et al. (2010). 'The Global Economic Crisis: Its Nature, Impact and the Conditions of Women in Africa.' *american.edu/.../economics/.../FloroTasTornqvist2010-impact-of-global-economic-crisis.pdf*

Ajakaiye, O. and Fakiyesi, T. (2009). 'Global Financial Crisis Discussion Series Paper 8: Nigeria. www.odi.org.uk/resources/download/3310.pdf

Chete, L. N. (2009). 'Global Financial Crisis and Challenges of Meeting the Economic - MDGs in Nigeria.' *www.economicsunibuja.org/nigeria_economic.../NES%20Global%20financial%20crisis%20and%20Economic%20MDGs%2..*

Fisher, H. (2010). 'Development Aid Rose in 2009 and most Donors will meet 2010 Aid Targets.' Development Co-operation Directorate (DCD-DAC), http://www.oecd.org/document/0,3746,en_2649_34447_44981579_1_1_1_1,00.html

Health-e (2010). 'AIDS Funds Fall Flat.' www.allafrica.com

Hecker, H. (2010) 'The Effects of the Global Economic Crisis: Examining the Impact on HIV & AIDS Funding Thus Far' **http://www.consultancyafrica.com/index.php?option= com_content&view=article&id=292&Itemid=197**

Kirigia et al. (2011). 'Effects of Global Financial Crisis on Funding for Health Development in Nineteen Countries of the WHO African Region.' BMC International Health and Human Rights 2011 11:4. **http://www.biomedcentral.com/1472-698X/11/4**

Mangvwat, A. P. and Mangvwat, B. M. (2010) 'Food, Health and the Economic Depression in Contemporary Nigeria (1979-2009)' in *The Social; Sciences* 5 (5) 391-400, 2010

Mitik, L. (2009) 'The Implications of the Global Economic Slowdown for Africa: A Synthesis' Center for Development Consulting Addis Ababa www.cdce.com

Muanya, C. (2009) 'Doctors Decry Reduction of Vote for Health in 2009 Budget' http://www.nigerianbestforum.com/index.php?

Musau, S.(2010)'Impact of Global Economic Crisis on Health in Africa' in *Africa's Health in 2010/AE*D, USAID, Washington D.C. *pdf.usaid.gov/pdf_docs/PNADQ002.pdf*

Toyo, E. (2002) *Economics of Structural Adjustment: A Study of the Prelude to Globalization*. Lagos: First Academic Publishers

WHO (2009). 'Global Health Observatory' http://www.who.int/countries/nga/nga/en/ Health Profile. Accessed 25/05/11

WHO (2009). 'The Financial Crisis and Global Health' Being Report of a High-Level Consultation World Health Organization, Geneva 19 January. P.3 Accessed on May 15, 2011.