

Fiscal Space for Health Financing in Nigeria

HYACINTH E. ICHOKU^{1,*}, CHIJIJOKE I. OKOLI^{2,3}

¹Department of Economics University of Nigeria – Nsukka

²Department of Health Administration & Management, University of Nigeria Enugu Campus

³Health Policy Research Group, University of Nigeria, Enugu Campus.

*Corresponding Author: hichoku@yahoo.com

Abstract

There has been increased demand for the funding of the health sector in many low and middle income countries including Nigeria. The disease burden in many of these countries strongly argues for increased allocation of resources to this sector. However, many policies makers are severely constrained by fiscal space. The object of this paper is to analyse the concept of fiscal space in the context of low income countries and various ways of increasing fiscal space to finance increased access to health services in LMICs using Nigeria as a case study.

Keywords: Allocation, Expenditure, Fiscal space, Health financing, Lagos, Nigeria, Tax

Introduction

Fiscal space for health financing refers to the ability of governments to increase spending for the health sector without compromising government's long-term solvency or crowding out expenditure in other sectors needed to achieve other development objectives.¹ It is additional public revenue which may derive from different sources which is kept aside to finance the health needs of the population. In a broader sense it refers to the availability of budgetary room that allows a government to provide resources for health without prejudice to the sustainability of a government's financial position.² That is, the government's present and future ability to cover its recurrent expenditures and service its debt. It involves policy actions for enhancing domestic resource mobilization, and the reforms necessary to secure the enabling governance, institutional and economic environment for these policy actions to be effective".³

With these definitional frameworks, one of the greatest challenges facing governments in low income countries (LICs) is how to increase the fiscal space for the financing of health services given the usual binding resource constraints in this countries.

Development resources have opportunity costs and as a result the deployment of fiscal resources to one sector of the economy implies the denial of the same to other needy sectors. Policy makers must therefore constantly weigh options and explore opportunities and costs of fiscal resource deployment to ensure that they yield maximum welfare benefits to the population.

Why Increased Fiscal Space for Health

Over the last two decades, health has become a central issue in the development discourse. Never has there been a time when the visibility of health problems particularly in the LICs has been so prominent in the development agenda.⁴ The ascendancy of health in the development agenda among both researchers and practitioners owed to awareness that health is a crucial factor in economic development; an insight obtained long ago by some economists including^{5,6,7} but which was first formalized by Grossman.⁸ For example, Fogel⁹ showed that improvements in the health of the British population accounted for about 30% of the growth in per capita income of Britain between 1790 and 1980. Other researchers using different health indicators have shown the close relationship

between the health of a country's population and its economic performance. For example, Steckel¹⁰ using stature as health variable showed that the correlation between a country's population average height and per capita income is in the range of 0.82 to 0.88, which is very high. Arora¹¹ using data spanning 125 years from ten developed countries, including Australia, Denmark, Finland, France, Italy, Japan, Netherlands, Norway, Sweden and Britain showed that improvements in health expectancy accounted for 30 – 40% of economic growth in these countries and this is comparable to the result obtained by Fugel⁹. Furthermore, the UN Commission on Macroeconomics and Health (CMH)¹² also observed that:

"In today's world, poor health has particularly pernicious effect on economic development in sub-Saharan Africa, South Asia, and pockets of high disease and intense poverty elsewhere. Sub-Saharan Africa has experienced chronic decline of living standards during the past generation, starting from the lowest base in the world. The heavy burden of disease, and its multiple effects on productivity, demography, and education, has certainly played a role in Africa's chronic poor performance"

The implication of the foregoing is that good health and elimination of pain and grief is not just an autonomous good, and end in itself which everybody desires for its own sake, but has far reaching economic value. It is a pre-condition for the production of other goods and services. Health expenditures are therefore investments in improved productivity, and elimination of poverty, and improvement of income of households and important factor of economic growth.¹³ As Muskin¹⁴ noted long ago, observed interest in health as a development factor also "...reflects the desires and aspirations of people throughout the world – people anxious to add weight to their demands for action against disease and illiteracy by showing that such action is not only humanitarian, but will make a major contribution to economic growth as well"

The realization that health is a catalyst in economic and social development provides the rationale behind donor countries and international bi- and multi-lateral development partners focus on development assistance to scale up activities tackling the health problems of LICs including the treatment of HIV/AIDS, reducing the scourge of malaria, eliminating Polio, financing immunization and vaccination and other programs designed to increase access to health services for the most vulnerable groups. More Global Foundations are also increasing resources available in the health sector of many developing countries and to

achieving the Millennium Development Goals (MDGs).

Rising Global Health Spending Gaps

There is increasing global health spending gap between developed and LICs. In many developed countries, there have been dramatic increases in government expenditure on health. The current global expenditure on health is estimated to be about \$4.1 trillion. The OECD countries account for about 80% of this amount. The United States spends 14.6% of GDP on health with a per capita health expenditure of US\$6103. Public health expenditure per person in Norway is US\$4508. Germany spends about 10.9% of its GDP on health while France spends 9.7% of its GDP on health. Canada, Australia and Sweden spend 9.6%, 9.5% and 9.2%, respectively, of their GDP on health.

The high proportions of total income of developed countries to health contrast sharply with the situation in LICs particularly in Sub-Saharan Africa (SSA). For example Burundi with US\$0.70 has the lowest public expenditure per capita in the world. The annual total government expenditure on health in Republic of Benin is US\$86 million or US\$10.5 per capita. Many African countries devote meagre percentage of their income to health and these accounts for the dismal health profiles in these countries. WHO also estimates that the global total per capita expenditure is US\$639. There are 64 countries (most of these are SSA countries) where annual per capital expenditure on health is less than US\$50.15 Yet recent studies also show that LIC account for 59.2% of total global DALYs lost as against 7.9% lost by high income countries indicating possible high level of correlation between expenditure on health and burden of disease. The correlation between a countries health expenditure and life health outcomes has also been established in literature. For example, Obrizan and Wehby¹⁶ show that a country's health expenditure is related to its life expectancy outcome particularly for countries with low levels of life expectancy.

The health sector is generally poorly funded in many low income countries (LIC). Several multilateral and regional organizations often stipulate minimum benchmarks for the funding of the health sector for countries but these are in reality hardly ever met in SSA countries. For example, the Macroeconomic Commission on Health (2001) stipulated that LIC should spend a minimum of 2% of their GDP on funding of their health sector but most LICs hardly ever meet this minimum benchmark. WHO estimates that that the minimum spending per person per year needed to

provide basic, life-saving services is between US\$35 – US\$50. Yet most SSA countries are far from meeting this benchmark. Similarly, the Abuja Declaration¹⁷ requires SSA countries to devote at least 15% of their annual budget to funding the health sector. Fourteen years after the Abuja Declaration, no sub-Saharan African country has met this minimum benchmark. At the global level it was estimated in 2005 that only \$280 billion of global health expenditure of \$2.5 trillion is spent in middle- and low-income countries. Developing countries have annual health expenditure shortfall of between \$30 billion and \$60 billion.¹⁸

The key objective of this paper is to examine the potentials for increasing the fiscal space for health financing in Nigeria not only to meet the requirements of international declarations on health financing but more importantly to meeting the increasing health needs of the population. This is particularly important as the health profile of the country has been of concern not only to the citizens but also to the international community. The Nigerian health indicators are in several dimensions below the African average. If Nigeria is to meet up with even African average health indicators, then there is compelling need to increase investment on health above the current rate. Furthermore, there are indicators that the health needs of the country are likely to grow in the future and therefore

requiring increased investment. Yet it is also realized that health financing is low on the scale of politicians in the country, requiring therefore increased pressure and advocacy to increase resources to the health sector.

Poor Health Financing in Nigeria

Public financing of health services derive basically from budget allocations which in turn is largely determined by petroleum taxes. National income from oil sales accounts for about 30% of GDP and in some years accounts for over 70% of foreign exchange earnings. Over the 1980s and much of the 1990s, dominated by military rule, the federal government expenditure on health services averaged less than 2%.^{19,20,21} The return to civil rule in 1999 witnessed significant improvements in public funding, increasing to 4.4% and 7% of total federal government expenditure in 2005 and 2006 respectively although the figure fell in subsequent years. Figure 1, shows the allocations to the health sector between 2005 and 2009 in nominal and real values. The figure shows that stagnation in real value of allocation to the sector between the periods.

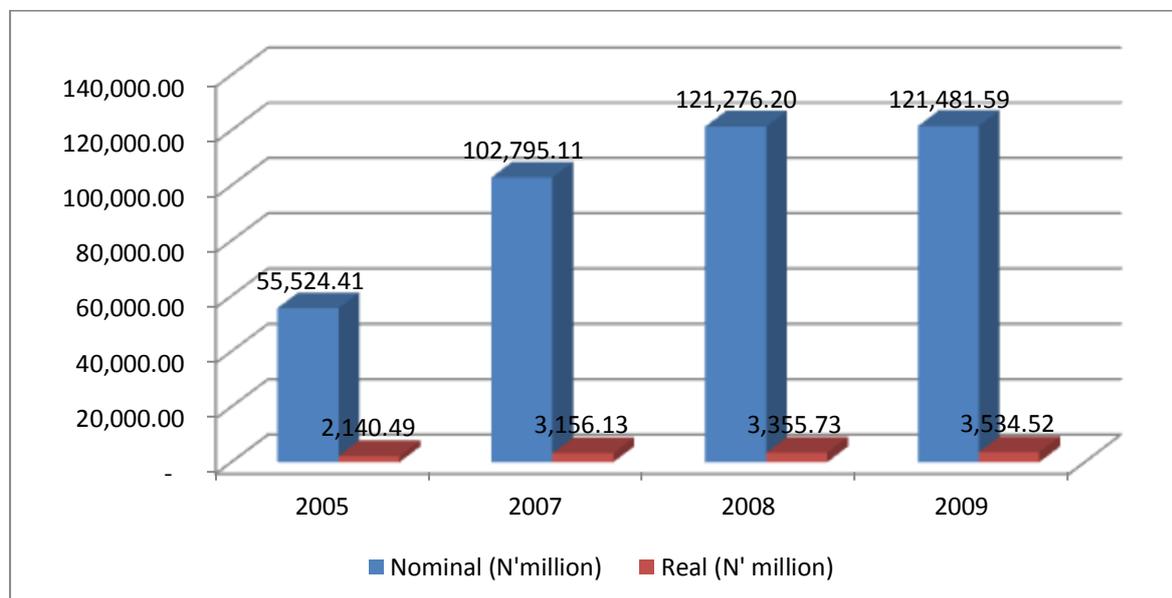


Figure 1: Nominal and Real Budget Allocations to Health (2005-2009)

Since health financing is also the responsibility of states it is also important to indicate the extent of resources available at state level to finance health services. Unfortunately, health financing data among the tiers of government, like in other sectors, are not consolidated to give a true picture of the size of total government expenditure on health.

However, evidence from Public Expenditure Review of the health sector in many states and National Health Account (NHA) suggests that on average most states in the country spend less than 5% of their total expenditure on healthcare. Expenditure from all tiers of governments amounts to less than 6% of total government expenditure and less than

25% of total health spending in the country. The balance of 75% is provided by the private sector. Household out-of-pocket expenditures account for over 95% of the private sector expenditure.²² OOP expenditures account for nearly 70% of the entire expenditure in the health sector.

The National Health Insurance Scheme (NHIS) has also potentials to contribute to the pool of resources available to finance health services in Nigeria through resource pooling from subscribers. However, although the scheme was established by law in 1999, and took off in 2005, it is yet to make significant impact in the health system of the country as it currently covers less than 5% of the population. Most of those presently covered by the scheme are public civil servants whose premiums are paid on their behalf by the federal government. The displacement effect of this policy on the provision of public health services and infrastructure is yet to be ascertained but likely significant as government has no separate resource pool for financing its payment of premiums for civil servants. The equity implication of the policy is also considerable as it implies the use of public resources to subsidize those with highest potential to contribute to the health resource pool in the country.

Furthermore, evidence suggests that most poor households either suppress their health needs by not reporting for treatment when they are sick, or by resorting to self-medication and patronizing cheap but unqualified drug vendors.²³ In many households, health expenditure has significant displacement effects on household budget, and in

fact, in many of such households health expenditures are catastrophic.²⁴ The Nigerian National Living Standard Survey (NLSS) of 2004 which had a representative sample of 1900 households indicated that out-of-pocket health expenditure was about \$22.5 per capita. This amount accounted for about 9% of total household expenditure and about 12% of households spent at least 25% of their incomes on health.²⁵

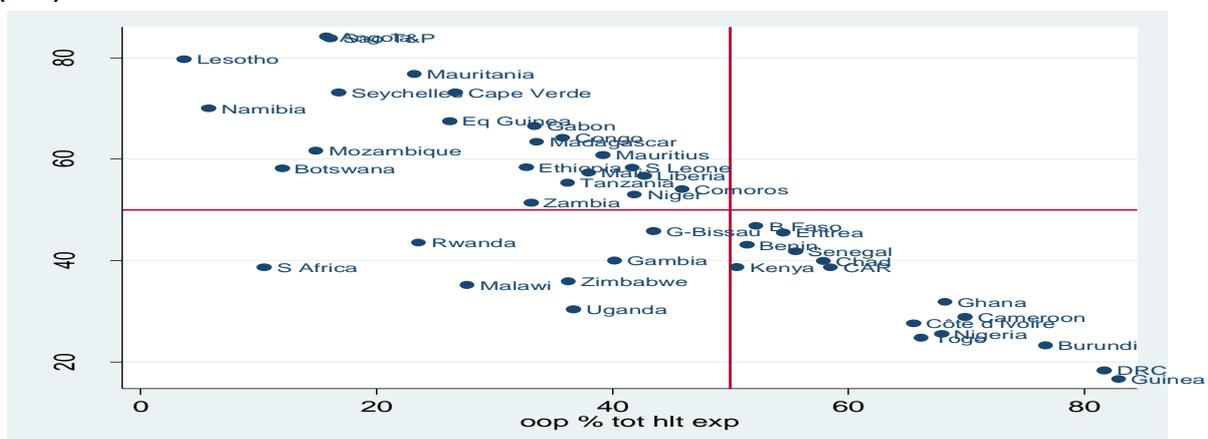
The poor public funding of health services by all tiers of government implies that households and individuals must have to increase their health expenditures to make up for the deficiency in government funding. This in effect implies displacement of households other necessary expenditures such household food expenses, children schooling expenses, shelter and other basic needs from the household budgets. These harmful effects are in fact accentuated in an environment of market oriented health system in which for-profit health providers dominate the market. Most Nigerians finance their health needs through out-of-pocket at the point of use which largely depends on ability to pay. Given the prevailing poverty level which is estimated to be currently about 60% in many states, most households can hardly afford their healthcare needs and the effects of budget displacement on household welfare must be a major source of concern to policy.

Figure 2: Government Health Expenditure (GHE) & Out-of-Pocket (OOP) as % Total Health Expenditure (THE) across countries.

¹In fact, the provision of Primary and Secondary health services is assumed to be the responsibilities of the state.

²The original intent the federal government had by paying premiums for in 2005 when the scheme took off was to demonstrate to the sceptical public the usefulness of the scheme. The benefits of the scheme would then convince the employees to take up the payment of their premiums while the government withdraws. But this policy has stuck and government now finds it difficult to withdraw as federal employees are unwilling to take up the responsibility of paying their premiums

Figure 2: Government Health Expenditure (GHE) & Out-of-Pocket (OOP) as % Total Health Expenditure (THE) across countries



Source: [26]

Across states, the level of financial mobilization by the public sector of the health system depends to a large extent on the role it plays in health care provision. Nigeria has a highly varied mix of roles of the public sector in the health sector among the different states. In some states, particularly states in the Northern geopolitical regions, the public sector provides over 90% of all the health facilities while in most states in the southern geopolitical zones, the private sector provides over 70% of health services, and these are mostly on fee-for-service basis.

Figure 2 compares government expenditure on health as percentage of total health expenditure across countries. It clearly indicates that the government expenditure on health is one of the poorest in Africa. Out of pocket expenditure is the dominant source of health finance in the country and accounts for about 70% of total health expenditure.

Nigeria Health Profile

The health profile contrasts sharply with the level of poor funding of the health sector. Most health indices are below the SSA average. For example, it has higher than SSA rates of under-five mortality, the highest number of maternal death in SSA. Although Nigeria is SSA's second largest economy with over 160 million people, large reserves of oil and gas reserves, and a growing economy, average life expectancy of 51.9 years remains below Africa's average (Table 1). More than 100 of the population live on less than \$1.5 per day.

Most health indicators of the country are also below

national and internationally recognised standards. The under 5 mortality rate (U5MR) is 143 per 1000 live births which is double the average rate for LICs.²⁷ Maternal mortality ratio in Nigeria is 545 per 100,000 live births (or 1 in 23 Nigerian women die from birth related causes compared to 1 in 66 for Ghana.²⁸ About 33000 thousand women (representing 10% of the world's total) die of childbirth related causes and one million children under five (also 10% of the world's total) die every year in Nigeria. The country remains one of the few polio endemic countries in the world. While the government expresses commitment to achieving the Millennium Development Goals (MDGs) by 2015, it is clearly evident that the country is not on track to achieving the critical goals for maternal and child health.

Nigeria's poor health status is also reflected in adequate levels of access to basic life saving health services, particularly for women and children. Access to health care services is very low. According to the 2008 Nigeria Demographic and Health survey (NDHS), only about 58% of pregnant women received antenatal care from a skilled provider, and only 39% of deliveries were assisted by a skilled provider. Access to basic child health services is also poor. Only about 20% of children aged between 6 – 11 months old received required antibiotics for acute respiratory infection, and 6% of children with fever received recommended treatment for malaria. The prevalence of malnutrition is also very high. About 41% of children under age five are stunted and 23% are severely stunted.

2011, UNICEF., op.cit

2011, Nigerian Demographic and Health Survey 2008.

Table 1: Nigeria's Health Expenditure and Health Outcomes Relative to other African Countries

	Life exp. (2011)	THE % GDP (2009)	PC HEXP	Public (%)	Private (%)
Algeria	73.1	4.1	191	80.6	19.4
Benin	56.1	4.2	32	55.2	44.8
Burkina Faso	55.4	6.4	38	61.7	38.3
Burundi	50.4	13.1	20	46	54
Cameroon	51.6	5.6	61	27.9	72.1
Chad	49.6	7	42	55.2	44.8
Cote d'Ivoire	55.4	5.2	57	20.7	79.3
Egypt	73.2	5	112	41.1	58.9
Ghana	64.2	8.1	53	53.2	46.8
Guinea	54.1	5.7	19	15.2	84.8
Kenya	57.1	4.3	33	33.8	66.2
Liberia	56.8	13.2	29	39.7	60.3

Madagascar	66.7	4.1	18	67.1	32.9
Morocco	72.2	5.5	156	34.4	65.6
Namibia	62.5	5.9	258	66.6	33.4
Niger	54.7	6.1	21	57.6	42.4
Nigeria	51.9	5.8	69	36.3	63.7
Rwanda	55.4	9	48	43.2	56.8
Senegal	59.3	5.7	59	55.6	44.4
South Africa	52.8	8.5	485	40.1	59.9
Tanzania	58.2	5.1	25	73.6	26.4
Togo	57.1	5.5	27	23.9	76.1
Tunisia	74.5	6.2	240	54	46
Uganda	54.1	8.2	43	19	81
Africa	56.8	5.9	89.4	46.8	53.2

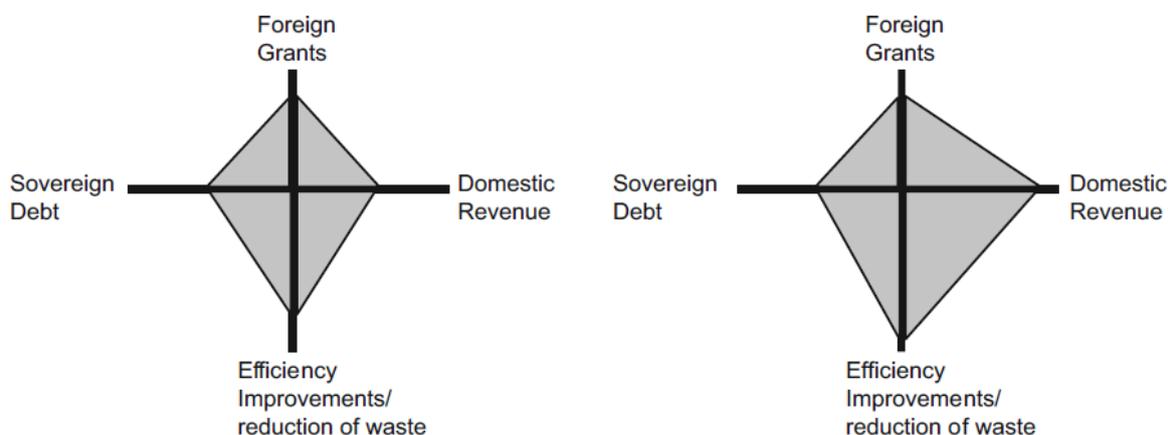
Source: [29]

Method

According to literature, fiscal space may be generated by raising revenues, increasing sovereign debt, accepting higher levels of development assistance, increasing efficiency, and reducing waste.³⁰ Hence, fiscal space can be graphically represented by a fiscal space “diamond,” which reflects the aforementioned four sources of fiscal space. In figure 3, the axe of the

diamond reflects the four areas of budgetary revenue, and the area of the diamond reflects the total available fiscal space, with larger areas suggesting more fiscal space. Fiscal space in the diamond on the right is greater because of increased possibilities for domestic revenue generation, and because efficiency is improved or waste is reduced.³⁰

Figure 3: Representation of Fiscal Space by a Fiscal Space Diamond



Source: [30]

Fiscal space for health could increase if the government reprioritizes health at the expense of other sectors.³⁰ Most of the literature on the fiscal space for health care has focused on budget reprioritization in favour of the health sector, increasing external funding for health care, generating sector-specific funding (e.g., dedicated taxes or mandatory health insurance) and improving efficiency in the use of health-sector funds.³¹ Currently, this approach has been emphasized by several international declarations calling for health to be prioritized within the government

budget. The Abuja Declaration, for instance, calls for governments in sub Saharan African countries to increase the share of their budget spent on health to 15 percent. Few countries in sub Saharan Africa are close to this target. As at 2010 only four African countries (Rwanda, Botswana, Zambia and Togo) were compliant with the Abuja pledge.³² Another oft quoted number comes from the Commission on Macroeconomics and Health, which estimated that countries need to spend a minimum of US\$34 per capita in order to provide a basic package of health services. Again only few low income countries spend close to this Amount.³⁰

In view of the foregoing, emphasis should be on increasing government revenue through the most progressive means possible as government revenue generation is the strongest determinant of government expenditure levels within individual countries.³¹ A government's revenue generating ability is influenced by factors such as natural resource reserves and policies on their exploitation, employment levels, the degree of tax compliance and the efficiency of revenue collection.³¹ For instance, a country like Nigeria with considerable mineral and other natural resources, a key starting point is to assess government policy on the exploitation of those resources and whether government revenue from that source could be increased.

Nevertheless, once government revenue has been increased, there is no guarantee that additional funds will be allocated to the health sector. Given that Ministries of finance hold considerable power in decision-making about the allocation of government revenue to individual sectors; hence the challenge is how to persuade them to invest more government resources in the health sector.³¹

Expected Key Drivers of Health Expenditures in Nigeria

As most developing countries double their efforts to achieve the MDGs by the target date of 2015 and beyond, there is likely to be pressure to focus more spending on the MDG related activities. In Nigeria the additional impetus to spend will arise from meeting the human resource and social dimensions of the Federal Government Vision 20:2020 development plan. The achievement of both the MDGs and Vision 20:2020 will significantly increase spending driven by the following factors:

Vision 20:2020

Achieving the health goals set out in the Federal Government Vision 20:2020 will be a major expenditure driver if those objectives are to be accomplished. The vision sets out the following health targets:

- Improve Nigeria ranking in the Human Development Index (HDI) from 157 rank (out of 177 countries) to 80.
- Reducing maternal mortality which available data indicate to currently stand at 545/100,000 by 75%.³⁴
- Reduction in under-5 mortality from 189 per 1000 live births; 33 to 75 in 2015 and 50 in 2020.
- Reduction in under-5 malnutrition from 53% to less than 20%³⁴ by the year 2015.
- Increased life expectancy of Nigerians from 47

years³³ to 70 years by 2020.

- Reduction in HIV/AIDs prevalence from 4.4 percent in 2006 to half by 2015.
- Improvement in the level of routine immunisation coverage from the present 27% to 95% by the year 2015.

Achieving these ambitious health goals would require drastic reprioritization of the current expenditure patterns and resource allocations in the country.

Expanding Access to Health Services

The Nigerian health system is dysfunctional in many dimensions including poor funding, understaffing, inadequate infrastructure, unclear line of management structures, inefficient supply chain, poor motivation, and skewed distribution of available health workers, among others. Overcoming these weaknesses constitute a major challenge to health system reform and would require extensive funding.

However, one of the greatest challenges facing the health system and which is going to be a key driver of health expenditure in the medium term and long term is expanding access to health services to include large populations in rural and hard-to-reach areas that currently not served or are underserved by the health system. Available data suggest that access to health services is below 60%.³⁶ This implies that over 60 million Nigerians do not have access to basic health services. A recent study shows that doctor to population ratio in some rural areas is 1:123000 while nurse to population ratio is as high as 1:67000. Reducing these health ratios puts the country under considerable pressure to increase investment in training more health personnel, building more health infrastructure, and redeployment and redistribution of existing health workers. Furthermore, greater effort to reach universal coverage through the National Health Insurance Scheme (NHIS) by bringing in people outside the formal sector would also require greater resource allocations than is presently available to the sector.

Improving Quality of Care

The Federal Ministry of Health (FMOH) has developed Minimum Service Package (MSP) for the provision of different forms of health services. These include infrastructural, personnel, equipment and drugs as well as standards of environment of health services provision. These MSPs have been developed for different levels of health care including Primary Healthcare and Secondary

Healthcare Services. Adherence to these MSPs has significant cost implications that will continue to drive the cost of health care services upward. It will require levels of expenditure far greater than what is currently allocated to the health sector at all tiers of government.

Demography

With a national population growth rate of 3%, Nigeria has one of the highest population growth rates in the world. The national census of 2006 showed the country had a population of 140 million people. This population is projected to rise to 193 million in 2020 and to 289 million by 2050.³⁶ The health expenditure implications of such a large population can be far reaching. Even sustaining the current level of poor health profile of the population will require more than internal available resources.

The current population structure of the country shows that about 45% of the population is less than 20 years indicating that the country has a very young population. Recent studies also indicate that Nigeria has a growing middle class. It is therefore expected that sustaining the growing middle class and the higher medical tests of this class and their children will require increase investment in the health sector. A growing middle class will in the long run lead to increased ageing population which will open another vista to health care expenditure.

Other Drivers of Health Expenditure

In addition to these, developments in medical technology, and the demands for enhanced salaries and wages by workers in the healthcare profession will put upward pressure on the health expenditure of the country. Increasing demand for medical treatment abroad including new medical destinations such as India and Saudi Arabia will add further pressure to health expenditure. Increasing cost of drugs and global pressures will exert further influence and lead to upswing in the cost of healthcare in Nigeria in the coming years.

Creating Fiscal Space for Health in Nigeria

Evidence from international literature suggests that sources of fiscal space vary across countries. A number of studies including^{4,39,38,39,40,41} have identified the following mechanisms for increasing available resources to public sector spending:

- Mobilisation of domestic revenues
- Increased discretionary expenditure through debt cancellation or increased borrowing
- Reallocation of expenditure between sectors
- Greater aid inflow to the domestic economy

- Improved efficiency in resource utilization and public expenditure management
- Political commitment to support an expansion in priority sectors of the economy.

Yet it is also known that the structure and size of revenue from different sources vary across countries implying that expansion of fiscal space for different sectors must take cognizance of the peculiarities of each country's economy. In the following we explore the possibility of increasing resources for health through relevant sources within current Nigerian fiscal arrangement.

Economic Growth

Evidence from international literature indicates that a countries per capita expenditure on health is highly correlated with GDP of that country.^{42, 43, 44} In fact, this is first law of health economics.^{45,46} Note that fiscal space is unlikely to grow faster than the GDP growth of a country.

Conducive macroeconomic environment including economic growth, improvements in revenue generation, low levels of fiscal deficits are important when considering the creation of fiscal space for any sector of the economy such as health. Tandon and Cashin¹, for example, observed that economic growth can lead to increases in fiscal space for health even if the government health spending share of GDP remains unchanged in a country. The underlying assumption, of course, is that policy makers would allow health allocations to increase at least equi-proportionally with the rate of general economic growth. Unlike in the 1990s when the economy stagnated, Nigeria experienced significant economic growth in the decade of 2000. From about 5.4% growth rate in 2000 the economy grew by 9.6% in 2003 before declining to 6.4% at the close of the decade. The growth rate during this period was largely driven by higher international oil prices and better performance of the non-oil sector, although oil revenue continues to account for the about 90% of foreign exchange inflow and more than about 80% of budget at the three tiers of government.

Ensuring that the fiscal space increases in tandem with the growth of the economy requires that the tax revenue contribution to GDP is optimal. Available statistics show that in 1995, the average of tax revenue to GDP in 46 Africa countries was 15.7%.⁴⁷ The average tax revenue to GDP ratio for Africa for the period 1990 to 1995 was 15.86%. The average for Nigeria was 7.82 compared to 22.56% in Kenya, 27.78% in Angola, 13.03% in Ghana and 24.21% in South Africa. Heller⁴ suggests that in LICs

particularly in Africa, the minimum revenue to GDP ratio should be about 15%. Countries with tax burdens below this minimum cannot afford to create fiscal space without tax overburden. However, countries with tax revenue to GDP ratio higher than 15% may find it difficult to create further fiscal space. But even at that further fiscal space may still be achieved through greater efficiency in tax administration and management.

The implication is that Nigeria has a large room for increasing fiscal space for the health sector through greater tax efforts. Considering the country's current GDP of about \$300 billion, an increase of tax revenue to 15% (ie additional 7%) of the GDP will result to about \$21 billion. Assuming an allocation of 10% of this additional income to the health sector would result to \$2.1 billion (or, at the current average exchange rate, N300 billion) for the health sector. This will represent a great leap forward for the health sector.

Creating fiscal space to address the huge health challenges facing a country like Nigeria requires a mix of policy instruments that addresses the following established sources of fiscal constraints: Macroeconomic conditions, prioritizing health expenditure, increasing the efficiency of health spending, among others. According to UNICEF³⁷, fiscal space is influenced by types of expenditure, public budgets and politics and the capacity of government to create that space in the future. This study built a framework that includes six principal mechanisms that must be taken into account in identifying potential fiscal space, which include: increasing revenue, reallocating spending, reducing debt, increasing borrowing, increasing aid and generating money by money creation.

Official Development Assistance

Several countries and regions, even the most advanced ones, are currently facing critical fiscal challenges. These challenges will affect the capacity of donor countries to give assistance to needy LICs including Nigeria. One of the most important fiscal challenges that are facing governments in both developed and developing countries is the containment of escalating cost of financing health services and fiscal consolidation. In most advanced countries the health sector has been one of the main drivers of government expenditure. It accounts for about 50% of the rise in total government spending over the past forty years. These spending pressures are expected to intensify over the next couple of decades driven mainly by factors such as aging of the population, economic growth, and technological advancements in the

health sector. On the other hand, the economic crises that started in 2008 caused government deficits to increase and have caused public indebtedness to rise to 100% of GDP in many OECD countries. The increasing level of economic uncertainties in recent years, widespread unemployment, stock market declines, and housing problems have generated new sets of concerns for developed and developing countries. Containing spending escalation and health sector reforms is likely to occupy a central position among policy makers both in the developed and emerging economies in the foreseeable future. In particular, the member countries of the Development Assistance Committee (DAC) that contribute about 80% of official development assistance (ODA) are increasingly focusing attention to domestic and regional debt stabilization and fiscal consolidation problems. Domestic and regional fiscal consolidation in OECD countries is likely to have serious implications for official development assistance which evidence shows tends to be procyclical. ODA inflow into the health sector of recipient countries increased from \$5.6 billion in 1990 to \$21.8 billion in 2007.48

ECA and APF (2008) estimated that Foreign Direct Investment (FDI) inflow into Africa increased from \$17.1 billion in 2002 to \$81 billion in 2007. Migrant workers' remittances inflow increased from \$4.6 billion in 2000 to \$20 billion in 2008. Official development assistance into Africa also increased from \$21 billion in 2002 to \$38.7 in 2007. For many African countries ODA constitutes more than 20% of GNI. There have also been similar decline in trade and prices of commodities which are major sources of income for African countries. For example, according to World Trade Organization (WTO) reports, African exports growth rate declined from 4.5% in 2007 to 3% in 2008 while import growth rate declined from 14% to 13%. The global financial threatens to reverse these gains.

According to a World Bank report of 2010, Nigeria received \$10.74 per capita in 2009. and \$8.56 in 2008. This amounts to an average ODA inflow into the country of about \$1.45 billion per year. Furthermore, Ekpo (n.d) suggests that 54% of total ODA inflow into Nigeria goes to support the health sector. In absolute terms, therefore, the amount of inflow into the health sector is about \$783 million (or about \$5 per capita). While this is a far cry when compared to other African countries where ODA makes up about 50% of their annual budget, this inflow is likely to reduce with increasing domestic economic crises in DAC countries of Europe and North America.

An important positive dimension to availability of

health resources in developing countries is the emergence of global funds initiatives. These include, the Global Fund for AIDS, TB and Malaria (GFATM), the activities of the Gates Foundation, the Global Alliance for Vaccines Initiative, the US President's Emergency Plan for AIDS Relief program, and the Affordable Medicines Facility-malaria (AMFm). These initiatives have contributed to increase significantly the global resources for health care in many developing countries particularly in SSA countries. In some countries, the resources from these multilateral organizations are channeled through the government budgets of the recipient countries. However, some have raised the question as to whether these resources have led to commensurate increase in health resources available in developing countries. In particular, it is well established that the per capita health expenditure at country level is largely a function of GDP per capita.⁴⁵

Reprioritization of Health Expenditure

One important mechanism for increasing the fiscal space for health in Nigeria is through the reprioritization of government expenditure by providing greater budgetary allocation to the health sector and other critical social services like education and water-supply and electricity. It is often the case that in many African countries health financing does not rank high in government expenditure outlay. The responsibility of financing health services is shifted to households. Unfortunately financing the cost of ill-health often falls on shoulders most unable to bear it. This results in catastrophic financing. There is therefore need to reprioritize health financing, not only because health is an end in itself but also because it is a pre-condition for productivity and economic growth as noted above.

The low priority accorded to financing of health in many SSA countries especially in Nigeria arises from the fact that health issues are often not visible in the political agenda. Politicians often do not reckon with it in their political campaigns. The result is that in the politics of budget preparation and resource allocation health is a marginal issue.

Unfortunately, reprioritization of public expenditure hardly takes place without advocacy, diplomacy, lobby, and contestation. Each sector of the economy is important and has advocates for its increased funding. Moving one sector a step above implies moving another sector a step down and such displacements cannot take place without superior arguments as to why one sector should move up while the other should be moved down

given limited available resources. As Ortiz et al.³⁹ noted, no extra resources are available and, therefore, other sectors or subsectors must be reduced in order to allow for increased investment in one sector and these sectors often represent some important vested political and social interests in a country. This therefore means that to be able to increase fiscal space for health we must be able to sacrifice expenditure for other areas that are less important to the society.

The budget is an instrument for resource allocation and priority setting. It is basically a site for contestation of power and resources⁴⁹ and therefore not just an outcome of economic rationality. It is above all, a political exercise. This understanding is particularly important in the context of a country like Nigeria, with huge resource needs, diverse political and social systems, and huge inequalities where the rich have access to the best care money can afford both locally and anywhere else in the world while the poor cannot afford basic treatment in a dysfunctional health system. In this respect, the players in the health sector and other key stakeholders in the health system must be ready to apply all legitimate means to achieve a higher prioritization of the health sector in the hierarchy of resource allocations in the country.

Increasing the Efficiency of health Spending

This refers to all attempts made to increase fiscal space by maximising the funds channelled for health care which therefore necessitates an improvement in health policies and institutions, identifying the key policy instruments of the health sector, targeting health expenditures and decentralizing the health care system. The efficiency of health spending could also be improved with the curtailing of corruption in the offices of health workers and the entire health system at large. According to Gottret & Schieber⁵¹, a country's capacities in rule-based governance, budgetary and financial management, revenue mobilization, public administration, transparency, accountability, and corruption in the public sector were all judged to be less conducive to growth. Therefore these sectors must be checkmated for a more efficient health system hence a broader fiscal space.

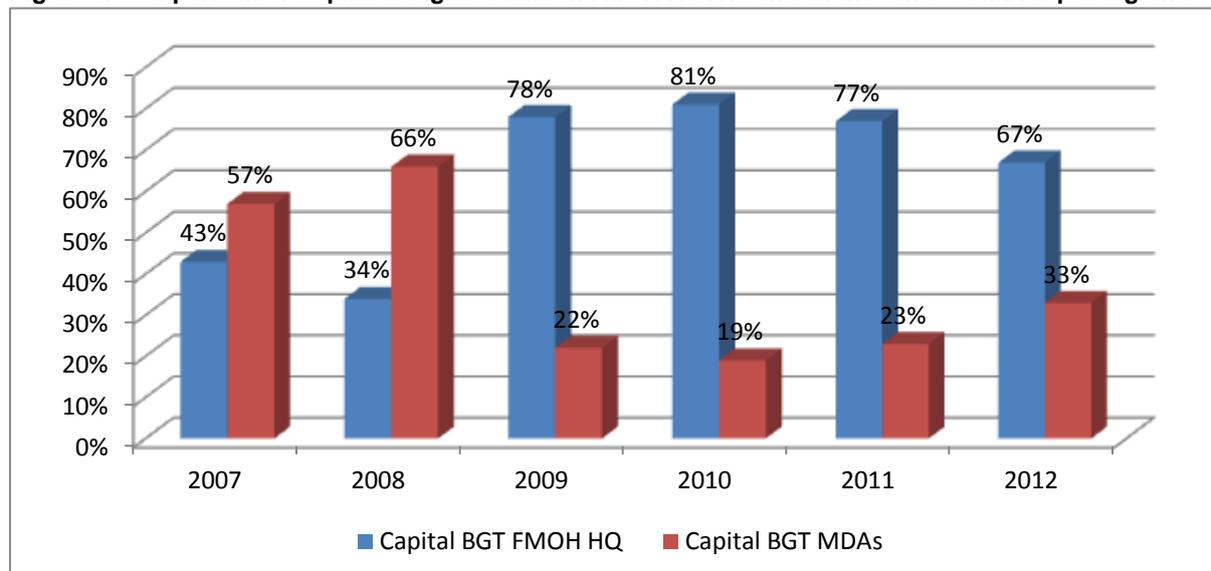
An important source of inefficiency and wastage in the use of health resources in Nigeria is caused by lack of symmetry between responsibility and resource allocation in the health sector. While the Federal Ministry of Health is supposed to be responsible for policy, regulation and general

stewardship role, the implementation and delivery of health services to the Nigerian population is the responsibility of different health delivery agencies including Federal Medical Centers, Teaching Hospitals, and state supervised frontline health delivery institutions such as general hospitals, Clinics, Primary Health Care Centers etc. These implementing agencies require large resources to be able to deliver on their mandate while the FMOH ensures that this is done through monitoring and evaluation. However, this is hardly reflected in the distribution of resources. The supervisory agencies use their power to concentrate resources under their control while the frontline delivery agencies are hardly financed. Such an arrangement creates a tension about where the balance of responsibility for the health system should lie.

The tendency to use power to concentrate funds at the centre over the years is shown in Figure 3. This

figure indicates the increasing propensity of headquarters of the FMOH to control huge capital budget. Given its relatively small recurrent spending, the headquarter allocates large shares of the capital budget to the centre with attendant corruption associated with award of contracts and diversion of funds. Given the correlation between the size of resources and the level of waste in institutionally inefficient system, it is not surprising that a lot of the waste and unnecessary expenditures noticed within the headquarters are located in the capital budget items. For example, the Ministry of Health allocated N1.23 billion to an undisaggregated activity of MDG projects and programme coordination and, tracking and assessments and special intervention on blindness and on oral health. There is no further explanation what this huge is to be used and how it is to be distributed among the various activities.

Figure 3: Comparison of Capital Budgets between FMOH HQTRs and all the other 84 MDAs put together



Source: Nigeria Approved Budget, various years

But wastage in the health system is not associated only with capital budget, it is also evident at frontline delivery units of health care. A recent study²³ using both the Data Envelopment Analysis (DEA), and Stochastic Frontier Models estimated large inefficiencies in the Nigerian health system. The study shows that based on input-output technical efficiency the average efficiency level in the Nigeria health system is about 60%. In other words, the present level of resources can increase output by as much as 40% which is currently wasted. The overall picture is that there is large fiscal space to be gained by improving the efficiency of the health system, removing corruption and improving performance of frontline delivery units.

Borrowing for Health Financing

The importance and sensitivity of the health sector permits it to be at the top of activities that could prioritize borrowing either locally or externally. According to Heller², Governments may choose to borrow without taking specific account of the direct returns from the particular expenditure item, but then must do so in the context of an assessment of the overall sustainability of a government's borrowing program, given the size of the government's existing obligations for debt service and principal repayments. Health expenditures are generally treated as recurrent expenditure, while many have argued that they should be viewed as an investment in human capital that will generate

taxable returns in the long run. This could go a long way to justify borrowing for public expenditure on health so long as the expected returns exceed the costs of servicing the debt.⁴⁰

Nigeria's current debt profile is about \$47.9 billion comprising both external and domestic debt. As at December 2011, the external debt was about \$4.58 billion but has been steady rise. The current debt to GDP ratio which is a measure of debt sustainability is about 17.3%. Although this is still below the country's specific debt-to-GDP threshold ratio of 25%, the current debt profile is already raising concerns given the assumptions belying this sustainability analysis. For example, it assumes increasing oil prices in the international market. It also assumes stable single digit inflation and budget deficit not exceeding 3% of GDP. The servicing of these debts will take significant percentage of the national budget to service every year. These assumptions seem overly optimistic given the current levels of these macroeconomic variables.

Furthermore, given Mr President's request for approval to borrow \$7 billion for infrastructural development in the country, it is unlikely that the priority of government would be to borrow to finance health services. This is especially unlikely given the poor appreciation in policy circles of the contributions of health to economic outcomes. Nigerians generally view health expenditure as consumption good rather than capital investment, thus making it more difficult to finance health services through borrowing.

Increasing Absorptive Capacity

While the lack of fiscal space has been a major hindrance to achieving set health goals in the country, there are also serious concerns about the absorptive capacity of the health system. In their seminal work "Absorptive Capacity: a new perspective on knowledge and innovation"⁵², defined absorptive capacity as "the ability of a firm to recognize the value of new external information, assimilate it and apply it to commercial ends..." The authors argued that this capacity is a function of prior knowledge. Beyond the field of innovation, absorptive capacity refers to the sector's ability to effectively utilize additional resources if this is provided. This problem is not just peculiar to the health sector but to other sectors of the economy as well. Sudden increases in financial resources may lead to wasteful spending indicating the inability of the sector to effectively utilize scarce resources at least in the short term. The most important inputs in the country's health production are the health human resources (doctors, pharmacists, nurses and

other auxiliary health workers), drugs, equipment and other supplies. It also includes the transportation system that ensures that health production inputs are made available where they are needed. More money for treatment might be wasted if additional doctors cannot be hired, or drugs cannot be delivered. Absorptive capacity constraints make it difficult to actualize increases in planned expenditures so that even if fiscal space exists, it may not get utilized because such constraints exist. The health sector is especially affected by absorptive capacity constraints with respect to human resources. The need for additional health sector resources is not in doubt, but without improving the absorptive capacity of the health sector, especially human resources, additional resources may not be utilized efficiently.³⁰ Unavailability of these resources imposes severe constraints to the effective functioning of the health system. Essentially, absorptive capacity is a short-term issue, which disappears once bottlenecks to handling additional resources are addressed.³⁰

In addition policies and cross-sectoral issues, cultural and religious practices, and even health policies, governance issues could also impose extra constraints in the supply or utilization of health resources. These factors impose constraints on the absorptive capacity of the sector. Pushing more money into the sector without ensuring that these bottlenecks are removed will not improve the health system. It can only lead to more corruption and mismanagement of the system. This is because insufficient absorptive capacity makes it difficult to realize the benefits of increased expenditures and, therefore, increases in fiscal space. In many states in Nigeria, particularly in the northern regions, labor is still a binding constraint to providing health services. In some other places, demand is also a big problem. The issues make the scaling up of available intervention difficult.

Conclusion

Expanding the fiscal space for health care is big challenge to the financing of Nigerian health sector. Over the years, poor funding has been militating against the achievement of health goals including the health related MDGs. Evidence suggests that it is unlikely that there will be dramatic expansions in the share of health spending without increased pressure on government and politicians to increase the funding of health services. While there are potentials for increasing the fiscal space for health through programs such as NHIS, the proposed Health Bill among others, it has to be acknowledged that financing the improvement of health profile of Nigerians to the level health indicators will compare

with even the African standards requires huge resources. It is however, critical that these potential sources are exploited to the full. It is for example, possible to expand the NHIS to the informal sectors to achieve universal coverage and to generate additional resources for the health sector. But the institutional weaknesses associated with the current structure and mode of operation associated with the NHIS makes it difficult for the scheme to play significant role in the Nigerian health system with modifications in the law setting it up. For example, it is unusual for a social health insurance to run on the basis of voluntary enrollment of the target group. Voluntary enrolment is more in the character of private health insurance schemes rather than social health insurance. Furthermore, the role of the scheme will remain only 'potential' given the level of poverty in the country where large proportions of the populations cannot afford basic needs of food and shelter. Under such circumstances, health risk aversion becomes significantly reduced and resource pooling becomes more difficult.

An important angle to the consideration of expanded fiscal space for the health sector in Nigeria is improvements in the performance of the Nigerian economy. Growth of the economy will lead to overall growth in the government budget which will in turn, hopefully, be reflected in increased funding of the health sector. However, the sources of growth of the Nigerian economy are dominated by oil exports and this is in turn dependent on exogenous factors including international oil prices with its frequent fluctuations and activities in the Niger Delta region. Although non-oil sector has been picking up in the last couple of years it is still a long way to buoying the economy to the level that will sufficiently generate required revenue to impact positively on the health sector. Furthermore, increasing the tax to GDP ratio from the current 8% to the 15% benchmark which could improve allocations to the health sector is a tough task given the strong opposition to increased taxes in the country. This strong opposition arises from the general deep distrust of government on account of pervasive corruption and lack of transparency in the use of public funds.

It would be unethical to argue for increased government funding of the health sector if resources were not used efficiently or equitably. Indeed, one of the reasons frequently advanced by ministries of finance for not increasing government funding of health services is the perception that the available funds are not being used efficiently.³¹ Thus the health sector must find ways of demonstrating that resources are being used efficiently. In particular, there should be good governance within the sector as failure to curb corruption is tantamount to failure

to use available resources efficiently.³¹

While international assistance remains an important source for creating health fiscal space, the future of this source is not very bright. Fiscal consolidation in the OECD countries is making donor countries to increasingly look inward. At the same time there is increasing attack on and doubts about the effectiveness of international aid as a platform for the development. The cumulative effect of these developments is the unlikelihood of using aid to expand fiscal space in the long run in developing countries.

There is also considerable space for fiscal improvements and absorptive capacity of the health sector through improvements in the utilization of available resources. Currently a significant percentage of health resources is wasted through inefficiency. It is however, recognized that improvement of absorptive capacity by addition of quality health workforce could substantially lead to improved fiscal space or the creation of virtual funds through efficiency gains.

In conclusion although Nigeria is unlikely in the short term to see dramatic increases in the fiscal space for health, expanding the NHIS towards achieving universal coverage and the signing into law the Health Bill which stipulates the setting aside 2% of the annual appropriation to fund PHC, represent potential paths to expanded fiscal space for health. The most promising part to expanding fiscal space for health in Nigeria seems to hinge on economic growth with increased distribution and stepping up political pressure through advocacy to increase the budgetary allocations to the health sector. Not spending an adequate amount in health may weaken the sector to the extent that it would, in the future, be costly and time consuming to "rebuild" the sector.²

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