Development assistance for health: trends and prospects

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The global economic crisis that began to unfold in 2008 has raised serious concerns about the ability of developing countries to meet targets for improvements in population health outcomes, and about the ability of developed countries to meet their commitments to fund health programmes in developing countries. This uncertainty underscores the importance of tracking spending on global health, to ensure resources are directed efficiently to the world's most pressing health issues.

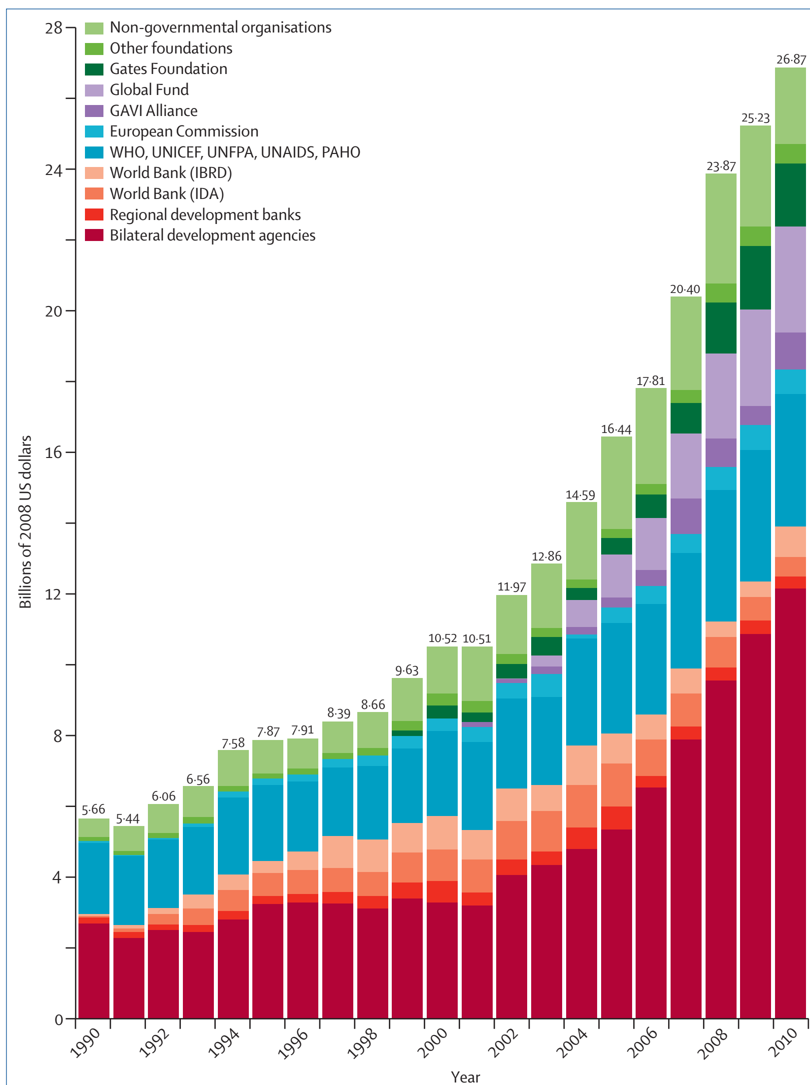

***Figure:* Development assistance for health by channel of assistance, 1990–2010**[2]
IBRD=International Bank for Reconstruction and Development. IDA=International Development Association. *2009 and 2010 are preliminary estimates based on information from the channels, including budgets, appropriations, and correspondence.

In 2009, Nirmala Ravishankar and colleagues from the Institute for Health Metrics and Evaluation,[1] reported on the massive expansion of development assistance for health between 1990 and 2007. This study introduced standardised definitions for tracking such assistance, and integrated financial statements, tax returns, and other data from the Organisation for Economic Co-operation and Development's Creditor Reporting System, UN health agencies, the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance, foundations, and non-governmental organisations. The findings gave quantitative detail about the expansion of global health, and the increase in the number of institutions and actors channelling these resources. New bodies, such as the Global Fund, GAVI Alliance, and the Bill & Melinda Gates Foundation, along with the UK's Department for International Development and US development agencies, were responsible for a rising share of development assistance for health, whereas some organisations (such as WHO) accounted for a steadily decreasing fraction of resources. We have now updated that information, publishing new data, analysis, and preliminary estimates associated with development assistance for health.[2] As part of this new study, we incorporated several key methodological improvements in response to reactions to our 2009 work.[1]

First, in addition to providing comparable figures for 2008, we generated preliminary estimates for 2009 and 2010. To do this, we examined the relation between past budgets and subsequent disbursements for bilateral development agencies, the European Commission, UN agencies, and the multilateral banks. These relations were used to project likely disbursements in 2009 and 2010, on the basis of annual budget data.[3] For foundations and non-governmental organisations, we forecasted disbursements in 2010 on the basis of information from financial data between 1990 and 2009, and key covariates, including gross domestic product per head and asset-value indices. Second, we used in-kind income as reported by US non-governmental organisations on their tax returns. Many non-governmental organisations use US wholesale prices for donated drugs and equipment. We studied the relation between US wholesale prices, international prices, and federal upper-limit prices for 386 unique products.[4,5] We used

regression coefficients for US federal upper-limit prices compared with US wholesale prices to correct in-kind income reported by non-governmental organisations. This analysis led to a downward adjustment of 82%, on average, for the figures based on tax returns from 1990 to 2010.

Development assistance for health by channel of assistance from 1990 to 2010 is shown in the figure, with dollars assigned to the institution that channels resources directly to the final recipient. Global health financing continued to expand between 2007 and 2010, from US$20·4 billion to $26·9 billion. Development assistance for health increased at an annual percentage rate of 17% between 2007 and 2008. But the growth rate slowed dramatically to just 6% between 2008 and 2009, and was 7% between 2009 and 2010. In absolute real dollars, the assistance increased by $3·5 billion, $1·4 billion, and $1·7 billion in 2008, 2009, and 2010, respectively. The shift in the balance of contributions between the different channels continued to be an underlying trend during this period, with UN agencies playing a smaller role and the Global Fund, GAVI, US and UK bilateral aid, and the Gates Foundation growing in importance as channels of assistance.

The underlying time series is shown by channel of assistance from 1990 to 2010 (webappendix). Careful examination of the rates of change in global health funding from 2006 to 2008 compared with 2008 to 2010 showed that the general expansion of development assistance for health masks diverse trends between the different channels. Some smaller funders, including Denmark, the Netherlands, Finland, and Portugal accelerated spending, as did the International Bank for Reconstruction and Development. The dominant funders, the USA and UK, maintained nearly the same absolute increase in spending over this period. Many other channels continued to spend more but at a slower rate than before, including the Global Fund, GAVI, WHO, UNICEF, the Gates Foundation, and the bilateral programmes of Australia, Canada, and Norway. The bilateral programmes of Sweden, Spain, Japan, and Germany remained nearly constant over the period. But the programmes of the Joint UN Programme on HIV/AIDS (UNAIDS), the Pan American Health Organization (PAHO), US non-governmental organisations, the Asian and Inter-American development banks, and the bilateral programmes of France and Italy showed real declines. Excluding the US and UK bilateral programmes, the Global Fund, the Gates Foundation, and GAVI, global health financing peaked in 2008 and has been slowly declining since.

It is notable that the key UN health agencies—WHO, UNICEF, UNAIDS, PAHO, and the UN Population Fund —have seen their fund reserves climb overall during this period of expansion in global health financing. At the end of 2009, these agencies collectively had $5·7 billion in reserves, representing 82% of their annual expenditures, an increase from 62% in 1999. Reserves might have accumulated for many reasons, including the complexity of managing a larger portfolio of extrabudgetary targeted resources. Reserve increases might also reflect institutional caution in scaling up staff and other activities, because a growing fraction of their budgets comes from voluntary contributions that can show up late in the fiscal year. Further analysis of the financial performance of different global health institutions and their strategies for managing uncertain fiscal flows deserve attention.

Our new study also examined patterns of development assistance for health by country and by health focus. The patterns continue to show the complex set of factors that influence total development assistance for health targeted to specific countries, including economic performance, burden of disease, countries' effectiveness in negotiating with donors, and historical and geopolitical factors. The top ten recipients were India, Nigeria, Tanzania, Ethiopia, Uganda, Kenya, Zambia, Mozambique, South Africa, and Pakistan. Generally, countries with higher disease burdens received more aid, but not always so. There are 11 countries that were in the top 30 recipients of development assistance for health from 2003 to 2008, but not in the top 30 in terms of burden of disease: Zambia, Argentina, Colombia, Ghana, Malawi, Rwanda, Cambodia, Senegal, Haiti, Zimbabwe, and Peru. We also examined assistance targeted to HIV/AIDS, tuberculosis, malaria, maternal, newborn, and child health, and non-communicable diseases. Funding for HIV/AIDS continued to rise, while programmes targeting maternal, newborn, and child health received the second largest share. Non-communicable diseases received the least amount of funding compared with other health areas.

See Online for webappendix

What are the likely trends in global health financing in the next 3–5 years? Will the scale-up continue, or will

the fiscal crisis of 2008 lead to flat or declining health expenditures? Global health spending from private sources, including non-governmental organisations and foundations, seems to track the economy closely. But it might take longer to know how the economic downturn will affect global health spending by governments of high-income countries. Logically, governmental spending on development assistance for health will depend on three factors: the size of government, the fraction of governmental spending on development assistance, and the fraction of development assistance spent on health. The reality is that after stimulus spending ends, high-income governments must reduce expenditures. Rising ratios of debt to gross domestic product will need to be reduced, requiring countries such as the USA and UK to move toward substantial governmental surpluses for several years.

The future of global health funding depends critically on the second and third factors. Sustaining or expanding the share of governmental expenditure for development assistance—although politically challenging—is not impossible. The UK's austerity budget has preserved expansion of international development assistance.[6] Incoming political leaders in the new US Congress, however, have stated that development assistance is unlikely to grow and might decline.[7,8] Equally important for global health is the trend in the share of development assistance devoted to health programmes, a share that has been steadily rising in the past decade. The evidence for whether health will remain a special priority is mixed. The Global Fund's replenishment for 2011–13 was $11·7 billion, which was less than the minimum $13 billion requested by the Fund, but a growth in pledges made between 2008 and 2010. However, because of recent media attention on misappropriated funds by some grant recipients, Germany, Ireland, and Sweden are considering halting some payments for 2011, and that could influence the total replenishment funds. On the other hand, the recently announced pledges of $49·3 billion for the World Bank's International Development Association—a nearly 18% increase over previous rounds—might indicate that the pendulum is swinging away from health-specific investment strategies and toward multisector investments, and toward budget support for low-resource countries in a time of fiscal contraction.[9]

Growth in global health spending will probably slow and might contract in 2011. We will enter a period of dramatically intensified competition for resources among the many important global health priorities. Although the global health community is unlikely to influence the politics of fiscal contraction, it can take on two specific challenges: provide compelling evidence that past and continuing investments are making an impact; and show that resources devoted to health programmes are an effective means to advance health and broader development goals. It will be crucial in this environment for the global health community to transparently evaluate and communicate about the successes and failures of global health funding. Only real evidence of success will sustain global health financing in coming years.

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