FINANCING GLOBAL HEALTH 2009:

TRACKING DEVELOPMENT ASSISTANCE FOR HEALTH

INSTITUTE FOR HEALTH METRICS AND EVALUATION

UNIVERSITY OF WASHINGTON

IHME

This report was prepared by the Institute for Health Metrics and Evaluation (IHME) through a research project funded by the Bill & Melinda Gates Foundation. The views expressed are those of the authors.

Institute for Health Metrics and Evaluation
2301 5th Avenue, Suite 600
Seattle, WA 98121
USA

To request copies of this report, please contact:
Telephone: +1 206 897 2800
Fax: +1 206 897 2899
Email: comms@healthmetricsandevaluation.org
www.healthmetricsandevaluation.org

ISBN 978-0-9840910-0-3

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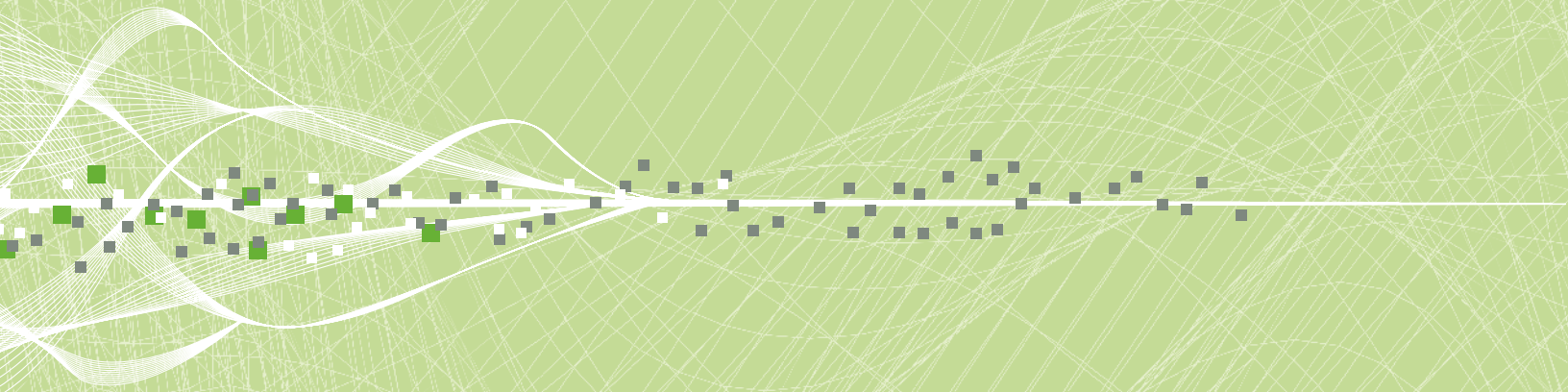
CONTENTS



ABOUT IHME

The Institute for Health Metrics and Evaluation (IHME) at the University of Washington monitors global health conditions and health systems and evaluates interventions, initiatives, and reforms. Our vision is that better health information will lead to more knowledgeable decision-making and higher achievements in health. To that end, we strive to build the needed base of objective evidence about what does and does not improve health conditions and health systems performance. IHME provides high-quality and timely information on health so that policymakers, researchers, donors, practitioners, local decision-makers, and others can better allocate limited resources to achieve optimal results.

ABOUT *FINANCING GLOBAL HEALTH 2009*

An overwhelming majority of the global burden of disease lies in low- and middle-income countries. In contrast, these countries account for a minor share of total global health spending. Given this discrepancy, it is not surprising that improving health in developing countries and mobilizing more resources to achieve that end have emerged as urgent development priorities. The first is reflected in the Millennium Development Goals, three out of eight of which pertain to health. The second is evidenced by the unprecedented rise in development assistance for health and the emergence of several new global health financing institutions in recent years.

Objective, comparable, and comprehensive information on public and private resources for global health is needed for improving the quality of policymaking and planning at all levels. It is also an essential ingredient for the effective monitoring and evaluation of global health initiatives and national health programs. The Organisation for Economic Co-operation and Development (OECD) routinely produces data on national health accounts which reflect public and private health expenditure for its member states.[1] Since 1998, the World Health Organization (WHO) has been committed to expanding national health accounts to developing countries.[2] While these are important efforts, there are major gaps in both the methods for measuring health expenditures and the available data.

To help fill these gaps, IHME is tracking three major components of financial resource inputs for health:

- **Development assistance for health:** Donor contributions are an important source of revenue for health systems in many low- and middle-income countries. Monitoring the volume of external aid and understanding its nature and composition is of vital importance to the global health community. IHME's research in this area focuses on generating valid, reliable, and comparable estimates of development assistance for health on an annual basis from 1990 onwards, and undertaking targeted research into its composition and effectiveness. The central questions this research seeks to address are: Who is giving what, how, to whom, and to what end? Does the distribution of global health resources across different disease areas, types of interventions, and geographical areas reflect current global health priorities? Are information systems for tracking aid transparent, and how may they be improved and standardized?
- **Government health expenditure:** Measuring how much governments in low- and middle-income countries spend on the health sector, both from domestic revenue and from funds received from external sources, is essential for understanding the performance of health systems in these countries. IHME's work in this area focuses on both generating the most up-to-date and valid time-series data on government health expenditure and undertaking research into the links between development assistance and national health expenditure. By how much does a dollar in external aid increase government

health expenditure in different recipient countries? Does foreign aid for health lead governments to reallocate their domestic funds to other sectors? These questions lie at the heart of this research area.

- **Private health expenditure:** Out-of-pocket payments by households for medical services constitute a large share of total health expenditure in most developing countries. These payments can often be catastrophic and can drive households into poverty. As developing countries enact policy reforms to alleviate the economic burden of accessing health care through different kinds of health system reforms, it is essential that we have accurate and comparable estimates of private health expenditures across countries and over time. IHME's work in this area will focus on validating existing methods, systematically analyzing all available data on private spending in low- and middle-income countries, and developing new tools for tracking private health expenditure.

IHME is launching an annual report on global health financing to present results from these three research streams and to make information about health spending widely available. This annual report will provide valid and consistent time-series data for tracking global health resources and in-depth analyses of timely and relevant research questions in all three areas described above. Disseminating our research findings to the widest audience possible will contribute to evidence-based policymaking, advocacy, and action. We also hope the reports will foster constructive debate and dialogue about the substantive research questions, the analytical methods, and the findings. We foresee this dialogue opening new avenues for consultation and collaboration, which will in turn serve to improve and strengthen the evidence base in the long run.

In *Financing Global Health 2009* we showcase our research on development assistance for health. The key results and methods presented in this report have been published in a research paper in *The Lancet*.[30] Government health spending and private health spending will be the focus of the reports in years two and three, respectively. In subsequent years, the *Financing Global Health* report will present annual updates and new research findings in all three areas, as well as in-depth analyses on special topics of interest in the area of resource inputs for health.

REPORT AUTHORS

Nirmala Ravishankar, PhD
Research Scientist
Institute for Health Metrics and Evaluation
University of Washington
Seattle, WA, USA

Paul Gubbins, BA
Post-Bachelor Fellow
Institute for Health Metrics and Evaluation
University of Washington
Seattle, WA, USA

Rebecca J Cooley, MEd
Data Analyst
Institute for Health Metrics and Evaluation
University of Washington
Seattle, WA, USA

Katherine Leach-Kemon, MPH
Post-Graduate Fellow
Institute for Health Metrics and Evaluation
University of Washington
Seattle, WA, USA

Catherine M Michaud, MD PhD
Senior Research Scientist
Harvard Initiative for Global Health
Harvard University
Cambridge, MA, USA

Dean T Jamison, MS PhD
Professor, Global Health
Institute for Health Metrics and Evaluation
University of Washington
Seattle, WA, USA

Christopher JL Murray, MD DPhil
Institute Director and Professor, Global Health
Institute for Health Metrics and Evaluation
University of Washington
Seattle, WA, USA

ACKNOWLEDGEMENTS

We would like to extend our deepest appreciation to the Health Financing Advisory Panel convened in 2008 and 2009 to guide our research efforts. The feedback and advice offered by panel chair Sir Richard Feachem, panel members Simon Scott, Julian Schweitzer, Daniel Low-Beer, Stephen Gloyd, Simon Miti, and Yonas Biru, and special invitees Charles Gardner, Manfred Huber, and Daniel Kress, at panel meetings were indispensable in shaping our research agenda and refining our findings.

We would also like to acknowledge all the people from development agencies, international organizations, non-governmental organizations, and foundations who responded to our requests for data and answered our numerous queries. We greatly appreciate their time and assistance.

Special thanks also go to members of the IHME family who have helped in innumerable ways to bring this report to fruition, including Julio Frenk, the chair of IHME's Board, for his guidance and advice; Jill Oviatt for managing the production of the report; David Sapienza, Christina Bernard, Shannon Harris, Jennifer Berthiaume and Haley Lee for assistance with data collection; Meghan Werner for program coordination; Kelsey Pierce, Linda Ettinger, and Kevin Wald for logistical support; and William Heisel, Kate Jackson and Stanislava Nikolova for assistance with editing the manuscript.

Finally, we would like to extend our gratitude to the Bill & Melinda Gates Foundation for generously funding this research and its unwavering support of our efforts to accurately track resource inputs for global health.

ACRONYMS

ADB	Asian Development Bank
AfDB	African Development Bank
AMC	Advanced Market Commitments
BMGF	Bill & Melinda Gates Foundation
CSO	Civil society organization
DAC	Development Assistance Committee
DAH	Development assistance for health
DALY	Disability-adjusted life year
DFID	UK Department for International Development
EC	European Commission
EU	European Union
G8	Group of Eight
GAVI	Global Alliance for Vaccines and Immunization
GBS	General budget support
GDP	Gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HNP	Health, Nutrition and Population
HSS	Health system strengthening
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IDB	Inter-American Development Bank
IFFIm	International Finance Facility for Immunisation
IHME	Institute for Health Metrics and Evaluation
IRS	United States Internal Revenue Service
ISS	Immunization services support
NGO	Non-governmental organization
NVS	New and underused vaccines support
ODA	Official development assistance
OECD	Organisation for Economic Co-operation and Development
PEPFAR	United States President's Emergency Plan for AIDS Relief
PPP	Public-private partnerships
UK	United Kingdom
US	United States
UNICEF	United Nations Children's Fund
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

LIST OF FIGURES AND TABLES

EXECUTIVE SUMMARY

Timely and reliable information on development assistance for improving health in low- and middle-income countries is needed for effective policy planning and for assessing the cost-effectiveness of development assistance. Past resource tracking efforts have failed to provide comprehensive and consistent time-series data on external resource flows for health.

A host of conceptual and measurement challenges plague this arena. One of the primary contributions of this study on development assistance for health (DAH) is developing an approach to tracking global health resource flows that addresses these challenges and provides valid, comprehensive, and systematic estimates of DAH from 1990 to the present.

We defined DAH as all assistance for health channeled through public and private institutions whose primary purpose is to advance development in developing countries. We drew upon a variety of data sources to measure the total volume of DAH that flowed through each of the channels of assistance net of any transfers to other channels also tracked by the Institute for Health Metrics and Evaluation. In addition, we analyzed the volume of aid for HIV/AIDS, tuberculosis, and malaria as well as the distribution of health aid across countries.

Key findings of the study are:

- DAH, measured in real 2007 US$, quadrupled from $5.6 billion in 1990 to $21.8 billion in 2007. The spending increased gradually until 2001 and then showed dramatic gains from 2002 to 2007.
- The fraction of health assistance channeled via multilateral institutions like the World Bank and United Nations agencies declined during the study period. New public-private initiatives for global health, specifically the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), and the Global Alliance for Vaccines and Immunization (GAVI), have been responsible for a large and rapidly growing share of DAH since 2002.
- Publicly financed health aid on average accounted for two-thirds of total health aid over this period.
- The flow of health aid from non-governmental organizations has hitherto not been captured by resource tracking studies. Their overseas health expenditure accounted for $5.4 billion out of the total envelope of $21.8 billion in 2007.
- Private philanthropy accounted for 27% of health aid in 2007. Donations from private philanthropic foundations, specifically the Bill & Melinda Gates Foundation, and corporate donations of drugs and medical supplies, make up over half of these flows.
- US contributions, including both public and private flows, accounted for a growing share of total health aid flows, up from 34.6% in 1990 to 51.1% in 2007. When we take the national incomes of donor countries into account, the gap between the US and other donor countries narrows. In terms of the ratio of each donor country's health aid to its national income, the US trails Sweden, Luxembourg, Norway and Ireland, but leads all other donor countries.
- In-kind contributions in the form of technical assistance and drug donations constitute a significant share of total health aid ($8.7 billion out of $21.8 billion in 2007). Given the current methods being used to assign values to those contributions, those figures may be inflated.
- Of the DAH in 2007 for which we had project-level information – a total of $13.8 billion – $4.9 billion was for HIV/AIDS, compared to $0.6 billion for tuberculosis, $0.7 billion for malaria, and $0.9 billion for health sector support.
- Overall, total DAH received by low- and middle-income countries was positively correlated with the burden of disease, while per-capita health assistance was negatively correlated with per-capita income. There are some strong anomalies, though. Some middle-income countries with lower disease burden – like Colombia, Iraq, and Argentina – receive large shares of DAH, while other much poorer countries with higher disease burden – like Mali, Niger, and Burkina Faso – receive relatively little funding.

The report documents the rapid and dramatic rise in DAH. It shows that the increase in DAH has been fueled by funds for HIV/AIDS, but other areas of global health have also expanded. The influx of funds has been accompanied by major changes in the institutional landscape of global health, with global health initiatives like GFATM and GAVI playing a more central role in mobilizing and channeling global health dollars. These findings confirm the need for systematic health resource tracking and greater transparency in development assistance reporting systems.

INTRODUCTION TO DEVELOPMENT ASSISTANCE FOR HEALTH

The past decade witnessed a rapid rise in development assistance for improving health in low- and middle-income countries. The emergence of several new global health players from outside the traditional nexus of bilateral agencies, multilateral organizations, and development banks that dominated the international aid scene in previous decades has accompanied this growth in resources. These new players have both mobilized resources for addressing global health challenges and successfully leveraged their funds to target specific diseases. The changes in the volume and organization of global health dollars have led to a lively debate among global health experts on the effectiveness of aid[3-7] and the impact of the new funding initiatives.[8,9] With economies around the world slipping into recession, the discussion has more recently turned to the potential decline in funding levels.[10-13]

Given these events, the lack of timely and reliable information on development assistance for health (DAH) is surprising. We know relatively little about the exact magnitude and impact of the rise in DAH because annual estimates of health funding from both public and private sources are conspicuously missing. We are also ill-equipped to answer basic questions like who is giving what, how, to whom and to what end. Such data are an essential ingredient for evidence-based policymaking and planning at the national level. The data are also needed for monitoring whether donors are honoring their commitments and can foster greater transparency in aid reporting. Understanding how financial aid flows into the health system is also an essential part of evaluating impact and cost-effectiveness.

The existing research on global health resource flows has yielded some important estimates and findings, but it does not provide comprehensive and systematic estimates of DAH over an extended period of time.[14-18] A majority of studies have relied on databases maintained by the Development Assistance Committee of the Organisation for Economic Co-operation and Development (OECD-DAC).[19-24] While these databases are a valuable source of information, they do not capture all external aid for health.[21,25] The biggest gap in coverage stems from the fact that the databases only reflect *official* development assistance (ODA) flowing from governments and leave out key private actors in the health domain like the Bill & Melinda Gates Foundation (BMGF), other private foundations, and non-governmental organizations (NGOs). A recent report by the Hudson Institute documents the steady growth of private philanthropy in the development assistance arena but lacks health sector-specific information.[26] A few attempts have been made to measure the overall DAH envelope, but these typically offer single-year snapshots[18,27] or cover a relatively small number of years and have not been updated to reflect contributions in recent years.[28,29]

The Institute for Health Metrics and Evaluation has launched a multi-year program for tracking DAH, which has addressed these conceptual and measurement challenges and developed a comprehensive system for global health resource tracking. The primary goal of the program is to develop consistent time-series data on DAH, which will be updated annually. This report showcases the program's research strategy and presents an in-depth analysis of DAH from 1990 to 2007. The underlying methods and key results have also been published in *The Lancet*.[30]

Chapter 1 describes some of the challenges involved in measuring DAH and the methodology we developed to address them. Chapter 2 presents our estimates of the total envelope of health assistance from 1990 to 2007. Chapter 3 takes a closer look at publicly financed DAH and its modalities. Chapter 4 examines the role of private actors in mobilizing DAH. Chapter 5 reviews the different types of international institutions that are active in the health domain and their individual contributions. Chapter 6 examines the distribution of DAH for specific diseases and specific countries. A discussion of the research findings and their implications follows.