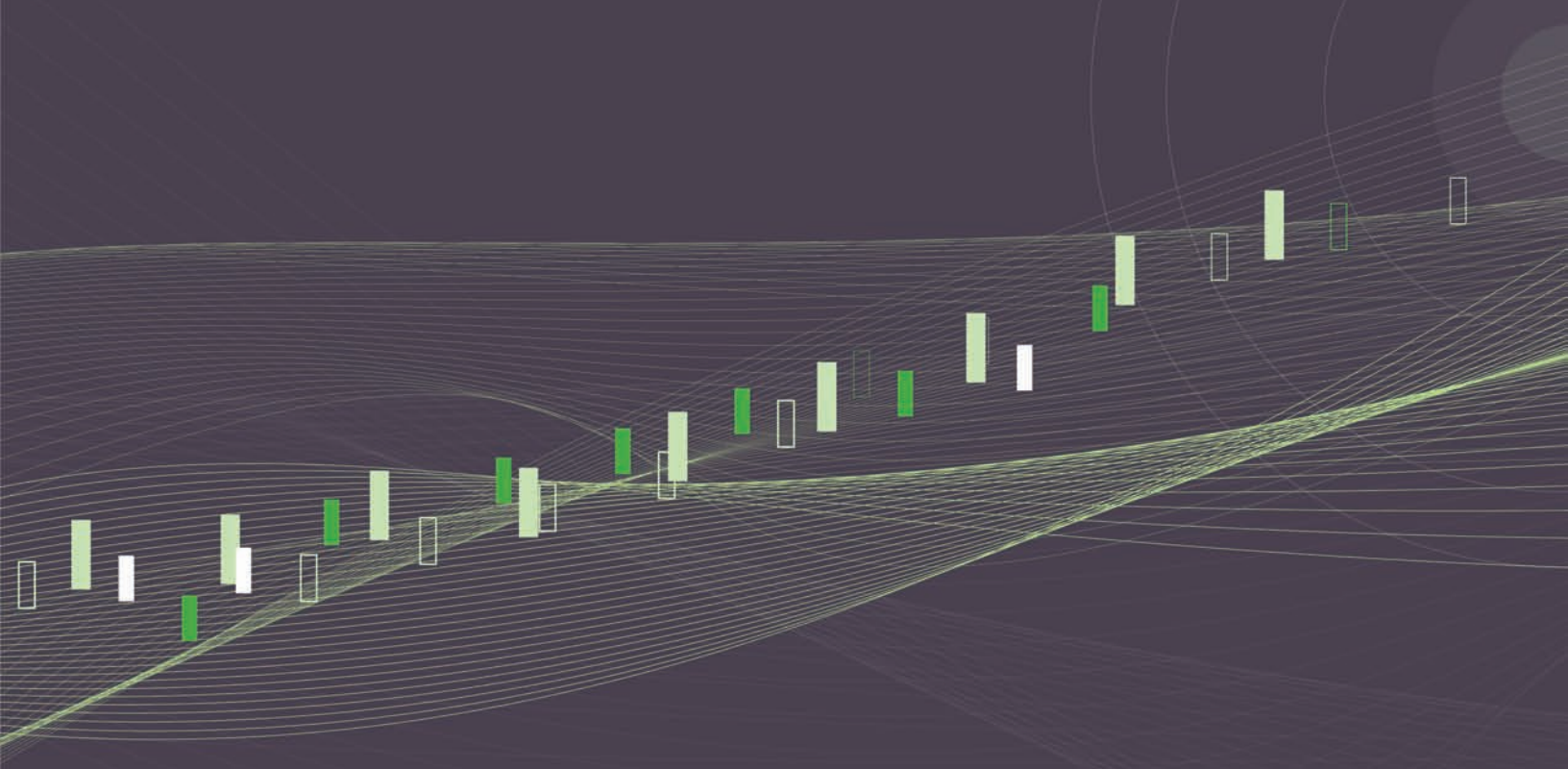
FINANCING GLOBAL HEALTH 2011:

CONTINUED GROWTH AS MDG DEADLINE APPROACHES



INSTITUTE FOR HEALTH METRICS AND EVALUATION

UNIVERSITY OF WASHINGTON

IHME

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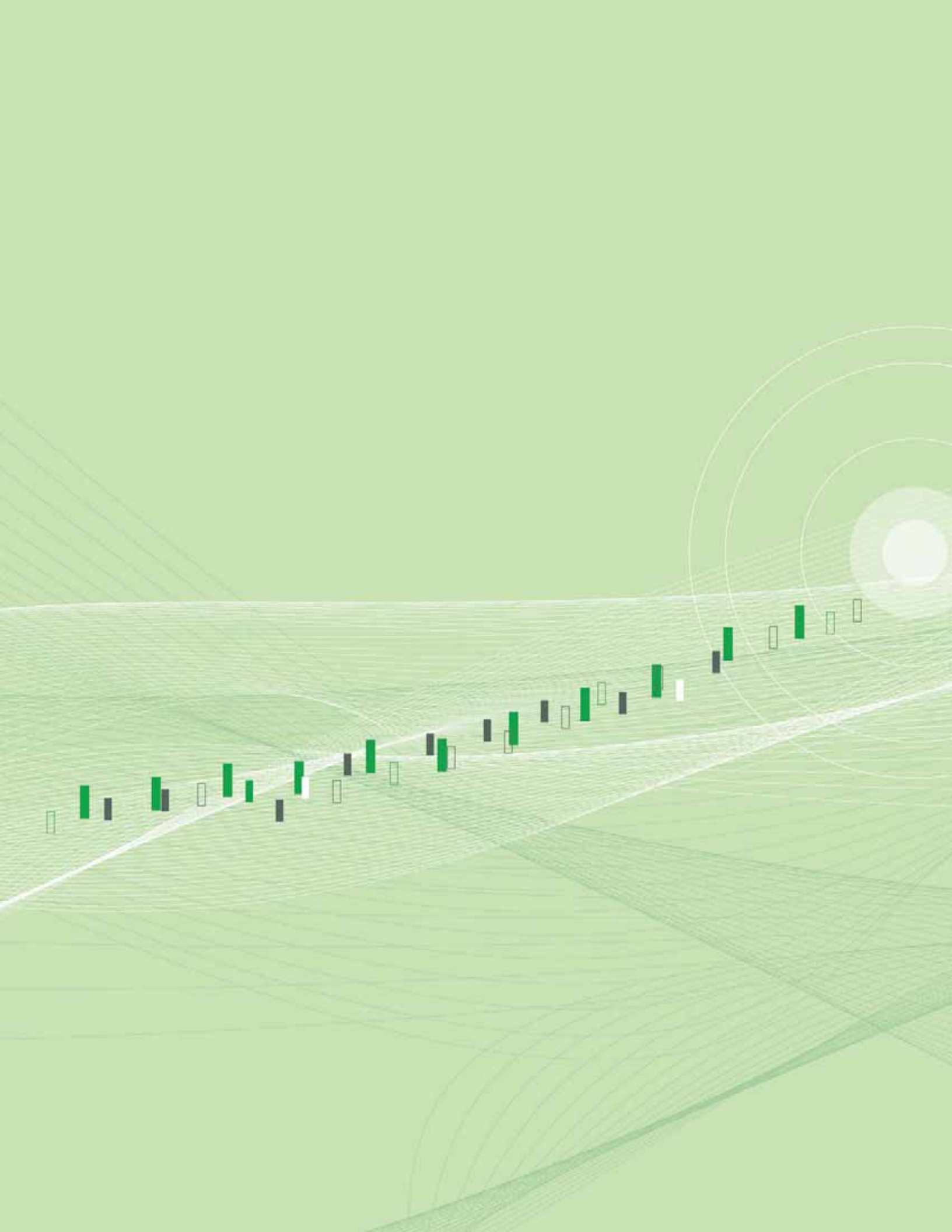

ABOUT IHME

The Institute for Health Metrics and Evaluation (IHME) is an independent global health research center at the University of Washington that provides rigorous and comparable measurement of the world's most important health problems and evaluates the strategies used to address them. IHME makes this information freely available so that policymakers have the evidence they need to make informed decisions about how to allocate resources to best improve population health.

For more information, please visit http://www.healthmetricsandevaluation.org.

ABOUT *FINANCING GLOBAL HEALTH 2011*

To help local, national, and international policymakers deploy scarce resources to best improve population health, IHME provides objective, comparable, and comprehensive information in an annual report on the state of global health financing. Now in its third year, *Financing Global Health* is a key component of IHME's mission to measure health conditions, assess the performance of societies in meeting health challenges, and maximize the impact of health policies and interventions.

In this year's report, we analyze two core elements of global health financing, development assistance for health (DAH) and government health expenditure, in the context of the approaching 2015 deadline to reach the Millennium Development Goals (MDGs), eight targets agreed to by the world's countries and leading development institutions. The MDGs range from halving extreme poverty to halting the spread of HIV/AIDS and providing universal primary education.

- **Development assistance for health:** IHME tracked every available financial stream to update our estimates of DAH from 1990 to 2011. We used data that are current as of 2009. Preliminary estimates for 2010 and 2011 were generated from models and preliminary financial statements obtained directly from some channels of assistance. As with last year's report, we estimate aggregate flows by source and channel. This year, we improved our estimates of DAH flowing through US-based non-governmental organizations (NGOs) by collecting additional health expenditure data from some of the largest NGOs. For our analysis of DAH for different health issues, we improved the accuracy of these estimates by incorporating more detailed data about projects' intended purposes from the World Bank. In addition, we began tracking the Bloomberg Family Foundation's investments in tobacco reduction initiatives, which has caused us to revise our estimates of DAH for noncommunicable diseases.
- **Government health expenditure:** Using data provided by the World Health Organization from 1995 to 2009, we analyzed how much money governments allocate to health, how health sector budgets have changed over time, and how DAH influences government spending on health. Understanding how country spending on health is affected by DAH is particularly important to funders, civil society organizations, and citizens and ministries of health in developing countries.

IHME's work in global health financing emphasizes the importance of transparency in health funding and the value of sharing data. This report also points out the need to more closely examine disparities in global health funding. In future years, we intend to expand the scope of our research to further examine the relationship between DAH and government health spending at the country level, as well as include tracking of out-of-pocket payments by households.

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We are grateful to past authors of this report for developing and refining the analytical and theoretical foundation upon which this report is based.

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Finally, we would like to extend our gratitude to the Bill & Melinda Gates Foundation for generously funding IHME and for its consistent support of this research and report.

ACRONYMS

ADB	Asian Development Bank
AfDB	African Development Bank
BMGF	Bill & Melinda Gates Foundation
DAH	Development assistance for health
DAH-G	Development assistance for health channeled to governments
DAH-NG	Development assistance for health channeled to non-governmental sectors
DALY	Disability-adjusted life year
EC	European Commission
GAVI	GAVI Alliance (formerly the Global Alliance for Vaccines and Immunisation)
GDP	Gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GGE	General government expenditure
GHE-A	Government health expenditure as agent
GHE-S	Government health expenditure as source
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IDB	Inter-American Development Bank
IGO	Intergovernmental organization
IHME	Institute for Health Metrics and Evaluation
IHP+	International Health Partnership and Related Initiatives
IMF	International Monetary Fund
MDGs	Millennium Development Goals
MNCH	Maternal, newborn, and child health
NCD	Noncommunicable disease
NGO	Non-governmental organization
NHA	National Health Accounts
OECD	Organisation for Economic Co-operation and Development
OECD-DAC	Organisation for Economic Co-operation and Development's Development Assistance Committee
OECD-CRS	Organisation for Economic Co-operation and Development's Creditor Reporting System
PAHO	Pan American Health Organization
PEPFAR	US President's Emergency Plan for AIDS Relief
PMI	President's Malaria Initiative
PPP	Public-private partnership
TB	Tuberculosis
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States
USAID	United States Agency for International Development
VA	Verbal autopsy
WHO	World Health Organization

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EXECUTIVE SUMMARY

Three years into a worldwide economic slowdown that has threatened the solvency of some governments, it remains uncertain when sustained growth will return to many national economies. In 2010, the Institute for Health Metrics and Evaluation reported there were concerns that the economic crisis would make it even more difficult for developed countries to meet their commitments to fund health programs in developing countries, and perhaps hurt the ability of developing countries to achieve the Millennium Development Goals (MDGs) for improving health in their populations. While there are signs that some donors and countries have started to pull back, overall development assistance for health (DAH) and total country spending on health continue to grow.

As with last year's report, *Financing Global Health 2010: Development Assistance and Country Spending in Economic Uncertainty*, this year's edition offers a comprehensive view of trends in public and private financing of health assistance with preliminary estimates for health financing in the most recent years. We also detail the trends in spending on health by developing countries and examine how DAH affects that spending.

Key findings of *Financing Global Health 2011: Continued Growth as MDG Deadline Approaches* include:

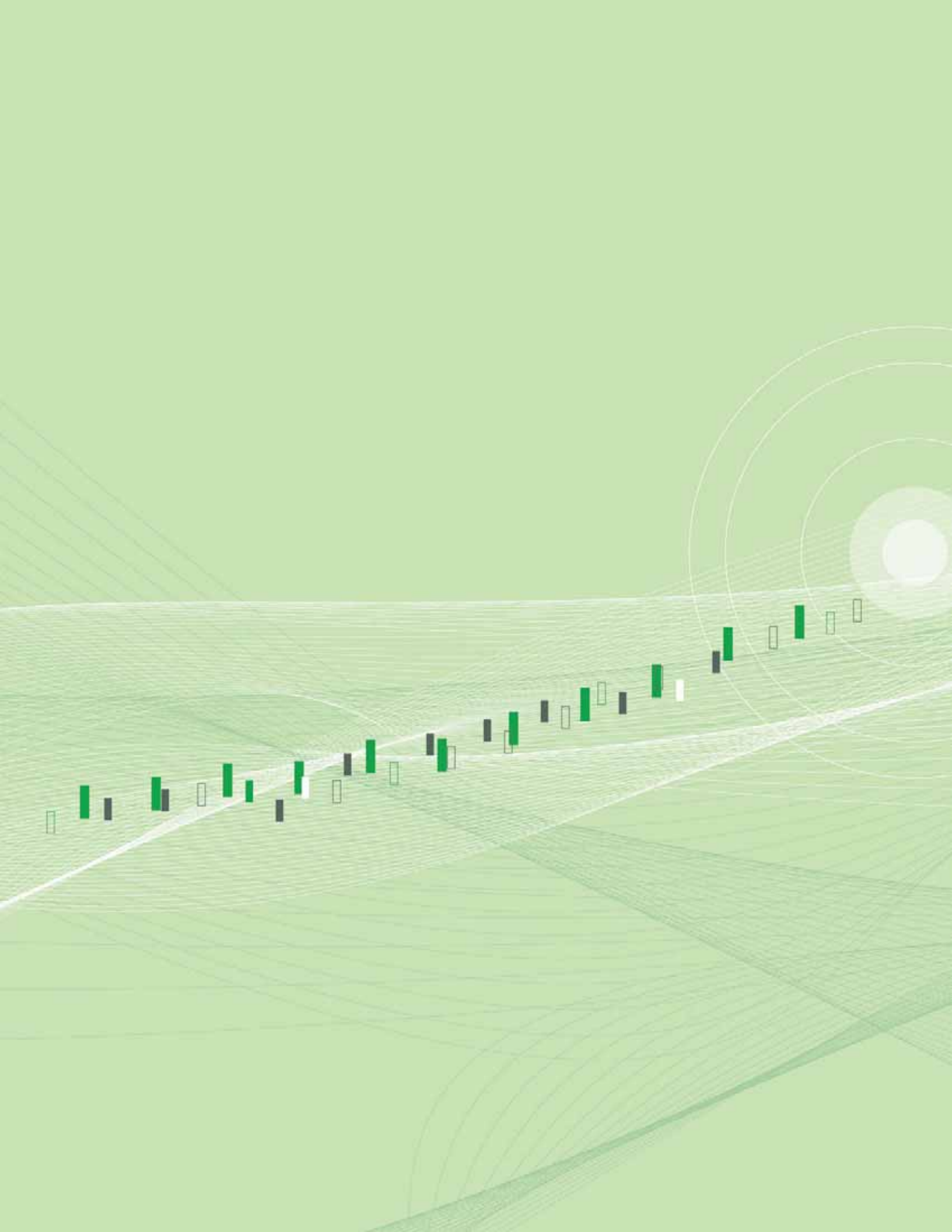
Development assistance for health

- DAH continued to rise through 2011, albeit at a slower rate than prior to the recession, to a total of $27.73 billion. DAH from some channels of assistance has dropped or stagnated, but other channels showed encouraging signs of faster growth.
- DAH more than doubled in size between 2001 and 2008. Following the recession, DAH increased 3% from 2008 to 2009, and 4% each year between 2009 and 2011.
- The World Bank's International Bank for Reconstruction and Development accounted for the largest share ($796.77 million) of the expansion in total DAH between 2010 and 2011.
- The strong growth in DAH from the United States over the past decade has slowed to 2% between 2010 and 2011.
- Following two years of declines in DAH, non-governmental organizations saw an increase in funding of 8% from 2010 to 2011.
- Sub-Saharan Africa received the largest amount of DAH ($7.61 billion, or 30%) in 2009, followed by South Asia ($1.85 billion, or 7.2%) and East Asia and the Pacific ($1.48 billion, or 5.8%).
- While DAH generally aligns with the countries that have the most significant disease burdens, 12 of the countries with the highest disease burdens, including Russia, Sudan, Myanmar, and Egypt, are not among the countries that receive the most DAH.
- Growth in DAH for HIV/AIDS, tuberculosis, and health sector support slowed between 2008 and 2009. DAH for malaria continued to grow rapidly, increasing by about 50% two years in a row, and growth in DAH for maternal, newborn, and child health and for noncommunicable diseases accelerated between 2008 and 2009.

Government health expenditure

- The global financial crisis does not appear to have slowed total public domestic spending on health. Spending accelerated between 2008 and 2009, increasing from $368.46 billion to $410.50 billion, 16 times the total amount of DAH spent.
- East Asia spent the largest amount of its own resources on health in 2009 (28% of total domestic health spending by developing country governments globally, or $113.85 billion), followed by North Africa/Middle East and Tropical Latin America.
- For every $1 of DAH that governments receive, they redirect $0.56 on average from the health sector to other spending priorities.

This report documents continued growth of DAH, despite concerns about cutbacks in foreign assistance. It also demonstrates continued strong growth in country expenditure on health, as well as the ongoing effects of DAH on spending for health by governments. With the MDG deadline rapidly approaching in 2015, it is important for policymakers to carefully assess the trends in these resource flows to decide where and how spending can have the maximum impact on population health.



INTRODUCTION

Global health advocates and funders have been watching two trends closely over the past year. The first is progress toward the Millennium Development Goals (MDGs). The second trend is the funding – both from donors and from the countries themselves – that is driving some of that progress.

A series of analyses were published this past year by universities, advocacy organizations, and United Nations (UN) agencies examining different aspects of the MDGs. The UN, for example, found in July 2011 that "the proportion of people going hungry has plateaued at 16%, despite reductions in poverty," making it unlikely that countries will meet the 2015 target of halving the number of people suffering from hunger worldwide.[1]

Dr. Rafael Lozano from the Institute for Health Metrics and Evaluation (IHME) and colleagues reported in September that only nine countries are on pace to achieve both MDG 4, which calls for a two-thirds reduction in the child mortality rate between 1990 and 2015, and MDG 5, which sets a goal of a three-fourths reduction in the maternal mortality ratio over the same period. They also found, though, that most countries in the world showed signs of accelerated progress in reducing both child and maternal mortality.[2] Studies credited the acceleration in the reduction of child mortality to a range of factors, including expanded use of insecticide-treated bed nets to prevent malaria and rising education levels among women.[3,4]

The last goal on the MDG list – MDG 8 – has received less attention than most of the other goals. It calls on developed countries to devise specific steps to raise the standard of living in developing countries. This goal builds on a series of agreements that started in 1970 with a UN General Assembly Resolution that said, "In recognition of the special importance of the role that can be fulfilled only by official development assistance, a major part of financial resource transfers to the developing countries should be provided in the form of official development assistance. Each economically advanced country will progressively increase its official development assistance to the developing countries and will exert its best efforts to reach a minimum net amount of 0.7 percent of its gross national product at market prices by the middle of the decade."[5]

At the 1992 UN Conference on Environment and Development, held in Rio de Janeiro, Brazil, and at the 2002 UN International Conference on Financing for Development in Monterrey, Mexico, this agreement was reaffirmed. It also became one of the underpinnings of MDG 8.[6] Since then, few countries managed to reach the aid target of 0.7% of their gross domestic product. In 2005, only five countries achieved that goal: Denmark, Luxembourg, the Netherlands, Norway, and Sweden.[7] Five years later, in 2010, the same five countries were the only ones meeting the target.[8]

Achieving aid targets is increasingly difficult for countries because of the ongoing global economic crisis. Even in countries where budgets are relatively stable, the high rate of unemployment and the loss of earning power among average workers have helped create a climate of suspicion about development assistance.

In the United Kingdom (UK), there has been repeated criticism from the public and from conservative politicians over Prime Minister David Cameron's insistence that the country's development assistance remain protected from budget cuts. One headline declared, "Foreign aid budget to cost every family £500: How 17 foreign aid fat cats are earning more than £90,000."[9] In the United States (US), key political leaders – including several candidates for the US presidency – argued that the US Congress should greatly reduce the amount of development assistance it provides each year in light of the country's historic debt levels.[10,11]

Debates about the future of development assistance come at a time when the world is recognizing the twin threat of the continuing high rate of infectious diseases in developing countries and the growing burden of noncommunicable diseases (NCDs). Earlier this year, IHME reported that cases and deaths from breast and cervical cancer are shifting to developing countries and to younger women in those countries.[12]

Reports this year also documented the rise in heart disease and increases in significant risk factors for disease, including obesity and high blood pressure.[13-15] In September, global leaders at the UN High-Level Meeting on Noncommunicable Diseases pledged to find new ways to combat NCDs, but there were no funding targets or specific goals set.

Tracking what spending was dedicated to NCDs and other health focus areas continues to be a challenge for IHME and other researchers. Data collection can lag by several years, making it nearly impossible to provide policymakers with timely analyses. For some countries, the data are sparse, creating a great amount of uncertainty around the estimates. Moreover, for some channels, little to no detail is available on how funding was allocated across health focus areas.

We were able to overcome some of those challenges for this year's report by gathering a broader array of data than was possible in previous years. We developed new analytical methods to generate more precise estimates of DAH and country spending on health from 1990 to 2009. These new methods strengthen our ability to make preliminary estimates for DAH in 2010 and 2011. In the future, we hope to produce estimates for country spending that are just as current as for DAH, as more and better data are gathered.

In Part One, we present a new time series of DAH for the years 1990 to 2009, with preliminary estimates for 2010 and 2011. We then analyze the trends in funding by channel, by source, by country of origin, and by type. We also examine the distribution of DAH by focus region, by recipient country, and by health focus area, including HIV/AIDS; tuberculosis; malaria; maternal, newborn, and child health; NCDs; and health sector support. In Part Two, we show the trends in developing country spending on health programs from 1990 to 2009. We also explore the relationship between DAH and health spending by developing countries. This full report can be accessed online at http://www.healthmetricsandevaluation.org/publications/policy-report/financing_global_health_2011_IHME.