CHAPTER 1

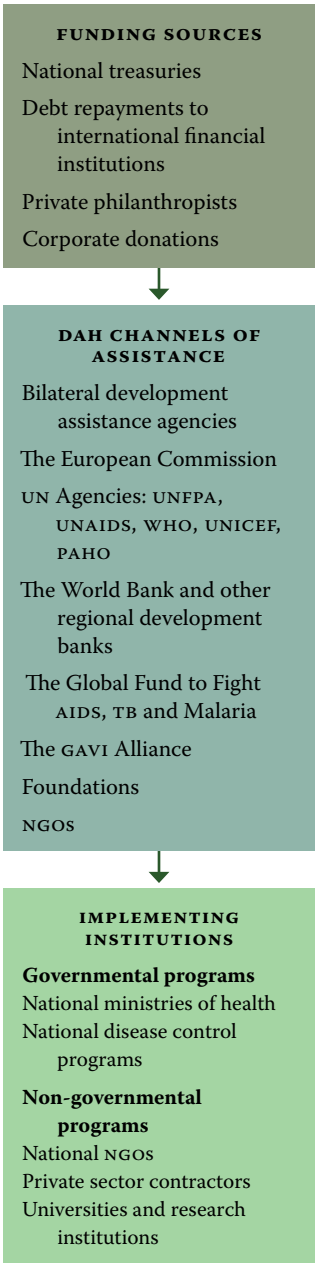
Overview of development assistance for health trends

This chapter uses estimates of development assistance for health (DAH) produced by the Institute for Health Metrics and Evaluation (IHME) to explore trends in global health financing from 1990 to 2013. Capturing DAH requires a framework designed specifically for parsing out the intricate flow of funds. Displayed in Figure 1, this framework provides a coherent foundation for IHME to categorize disparate funding streams into stages of disbursements. Moreover, it allows researchers to address double-counting that would otherwise lead to overestimation.

Using this approach, IHME tracks the flow of funds from their origin to their final destination in low- and middle-income countries. As shown in Figure 1, sources, or the origin of funds, typically consist of national treasuries or the private holdings of philanthropists and corporations. Sources transfer funds to channels, which are the multilateral and bilateral aid agencies, development banks, non-governmental organizations, and other actors that manage the distribution and delivery of development assistance. Because these organizations are relatively few in number and their financial data are readily available, IHME collects data primarily from channels. The flow of funds concludes with implementing institutions: the governmental and non-governmental entities that manage health systems, provide clinical care, and implement public health measures in developing countries.

Sources, channels of assistance, and implementing institutions are not mutually exclusive. A developed country government, for example, can serve as both a source and a channel. For instance, Germany acts as both when funds originating with the German tax base are provided as DAH through the country's bilateral aid agencies. Some channels also act as implementing institutions. The World Health Organization (WHO) plays the role of channel and implementing institution in amassing polio eradication funds and then providing immunizations directly to individuals.

FIGURE 1
Sources, channels, implementing institutions

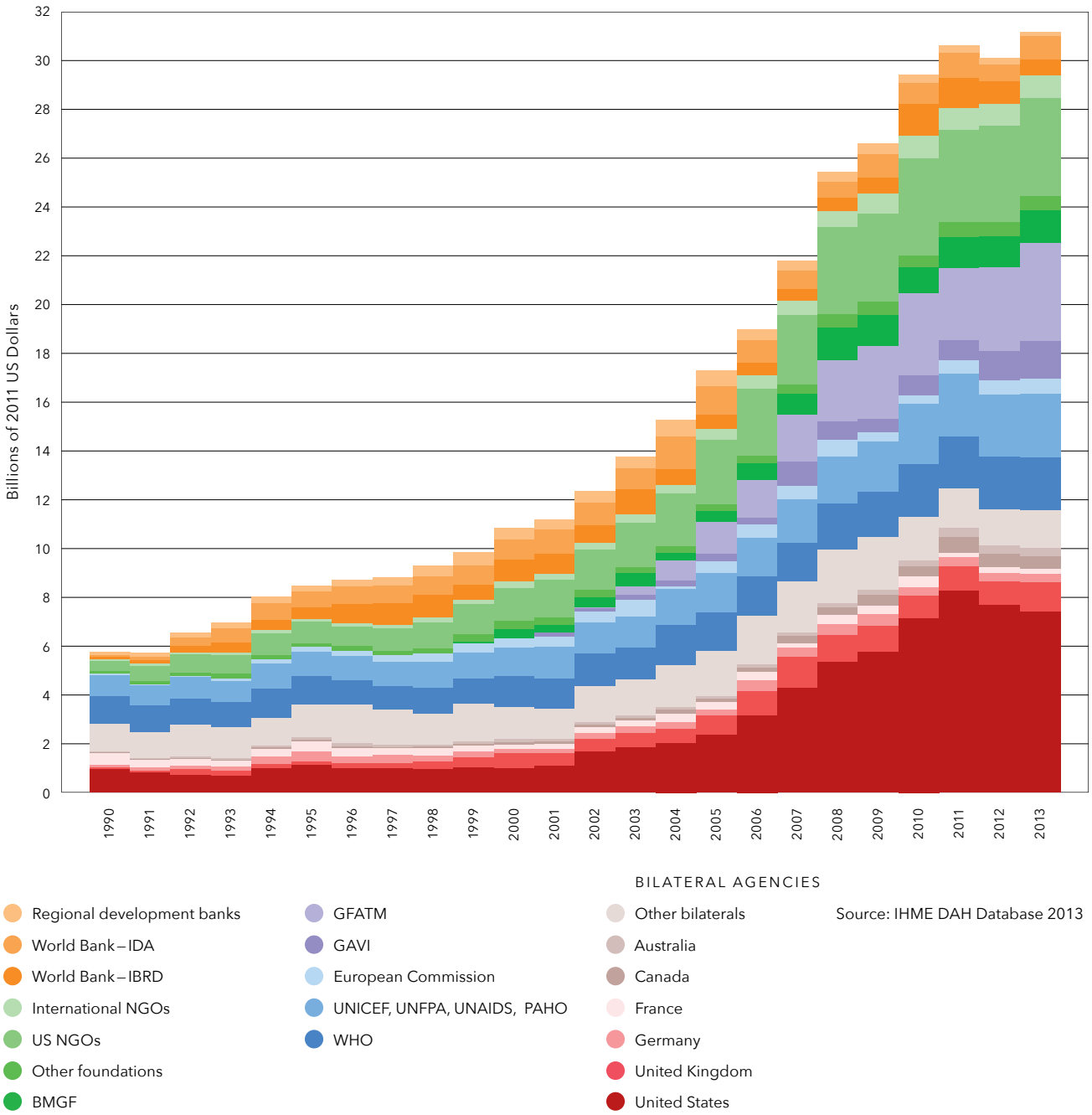


DAH BY CHANNEL OF ASSISTANCE

2013 marks the largest amount of DAH ever recorded. Preliminary estimates set 2012 DAH at $30.1 billion and 2013 DAH at $31.3 billion. DAH continued to climb in 2013 despite the lingering effects of the global financial crisis and the austerity measures implemented across Organisation for Economic Co-operation and Development countries. Budget cuts were instituted in the United States, the United Kingdom, Germany, France, Italy, Spain, and others as a response to the economic downturn.[9,10] Official development assistance, including DAH, was widely discussed as a potential target of spending cutbacks.[1-5] Thus, while the 1.1% increase in DAH from 2011 to 2013 falls short of the annualized growth of 11.3% observed over

FIGURE 2

DAH by channel of assistance, 1990–2013



2001–2010, the expansion is nonetheless an encouraging development for global health, particularly as the deadline for the Millennium Development Goals draws near.

The overarching trend is underpinned by shifts in the spending of different development assistance partners. Over 2012–2013, public-private partnerships led growth rates among channels. Certain non-governmental organizations (NGOs) also contributed substantially to this growth. Simultaneously, bilateral agencies' contributions on the whole remained steady. Decreases in DAH by a few major bilateral agencies

were offset by substantial increases by other countries, with the UK leading bilateral DAH growth. The DAH disbursed by most other types of development assistance partners, including United Nations (UN) agencies, development banks, and private foundations, also remained relatively unchanged.

Over 2012–2013, the UK's bilateral assistance, fed mostly through the Department for International Development (DFID), fueled growth in total DAH. UK DAH grew from $976 million in 2012 to $1.2 billion in 2013, a year-over-year increase of 24.7%. The increased investments were mostly made in low-income countries in sub-Saharan Africa as the UK continues to phase out development assistance to select middle-income countries. In addition to discontinuing aid to India, in early 2013 the United Kingdom announced it would end development assistance to South Africa by 2015.[11,12]

Spending by the European Commission (EC) underwent minor growth. The EC's DAH rose slightly, from $616 million in 2012 to an estimated $630 million in 2013. The DAH provided by individual countries in Europe also grew. IHME estimates that Swiss DAH grew 6.8% to $59 million in 2013. Reinforced by a strong economy, Switzerland plans to maintain increases in development assistance into 2014.[13] After years of cutbacks to development assistance, Italy's DAH rose 2.3% to $68 million in 2013, as the government sought to invest in sectors where Italy could establish a comparative advantage, including global health.[14] Swedish DAH grew an estimated 7.6%, to $152 million, in 2013. IHME's preliminary estimates show that the DAH of Austria, Belgium, Denmark, and Finland increased from 2012 to 2013 as well.

Elsewhere in Europe, the contributions of major bilateral agencies fell slightly vis-à-vis historical levels. German bilateral health aid dropped 2%, decreasing from $354 million in 2012 to $347 million in 2013. The reductions in German official development assistance were reportedly tied to efforts to minimize the borrowing of Germany's development ministry.[15] Spain's DAH also incurred cutbacks, dropping from $75 million in 2012 to $74 million in 2013 according to IHME's preliminary estimates. French DAH contracted slightly as well, decreasing from $231 million in 2012 to $207 million in 2013. However, French commitments to global health will be bolstered in coming years with an augmentation of taxes on the purchase of airline tickets. These funds will reportedly be used in part to combat HIV/AIDS, malaria, tuberculosis, and other infectious diseases.[16]

In North America, preliminary estimates show DAH is contracting. After peaking in 2011 at $8.3 billion, US bilateral assistance fell 7.2% from 2011 to 2012 and 3.4% from 2012 to 2013, leaving 2013 US DAH at $7.4 billion. This decrease can be tied to budget sequestration measures, which had an across-the-board impact on US government spending, including global health.[17] Despite the contraction in expenditure, global health continues to be high on the US development agenda. In 2012, the US established the Office of Global Health Diplomacy, which aims to provide diplomatic support to the US's Global Health Initiative.[18] The US also continues to prioritize the President's Emergency Plan for AIDS Relief (PEPFAR).[19]

Decreases were also observed in Canadian bilateral assistance. Canada's DAH dropped from $542 million to $491 million over 2012–2013. Notably, Canada implemented changes in its aid infrastructure in 2013. The Canadian International Development Agency was transferred to the Ministry of Foreign Affairs, a move intended to more closely align Canada's development aid with trade and foreign policy objectives.[20]

Among other bilateral agencies, Australia's bilateral aid remained nearly steady. Australia provided $339 million of DAH in 2013, which was an increase of 2.1% over 2012. However, in 2013, a new Australian government announced plans to reduce development assistance in coming years.[21]

The World Bank's International Bank for Reconstruction and Development (IBRD) and International Development Association (IDA) displayed different trends in expenditure, as tied to the role these distinct institutions play in financing global health. In 2010, IBRD responded to the economic crisis with large disbursements of aid. As the need associated with the crisis subsided, IBRD DAH has also been reduced. Nonetheless, in 2013, IBRD's contribution to DAH amounted to $883 million, an amount larger than any year between 2004 and 2009. In contrast, DAH from IDA, which focuses on low-income countries, and which convened replenishment meetings throughout 2013, jumped a substantial 21.4% relative to 2012.[22] Its DAH reached $861 million in 2013.

Following a decade of rapid growth, public-private partnerships continued their rise into 2013. The GAVI Alliance (GAVI), at $1.5 billion in 2013, grew markedly, increasing an estimated 32% from an already substantial $1.2 billion in 2012. Buoying GAVI's growth was the Islamic Development Bank, which announced the release of substantial contributions to GAVI in 2013.[23] Funds will be used to vaccinate over 400 million children across 29 Islamic Development Bank countries.

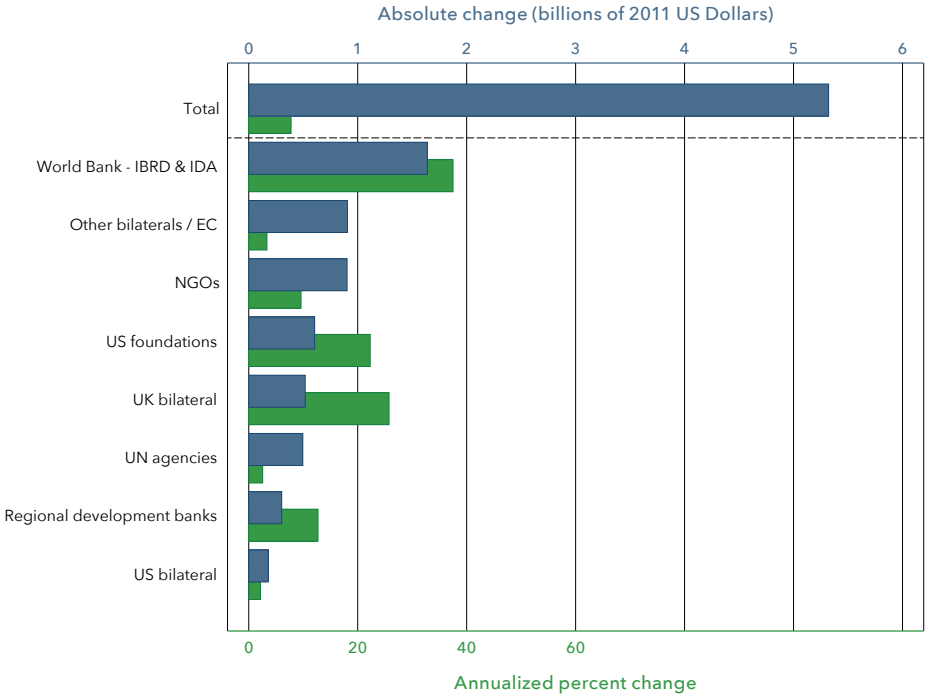
The other major public-private partnership in global health, the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), eclipsed its previous peak with expenditure of $4 billion in 2013. This was an increase of 16.8% from 2012 levels. Part of GFATM's recent expansion is related to reforms in its disbursement structure and other operations. The 2013 uptick was fueled by advance disbursements in six countries and three regional organizations, providing access to more than $400 million in funds that were part of the initial deployment of the New Funding Model.[24] Even before the New Funding Model was finalized, GFATM received substantial commitments from the UK ($1.6 billion)[25] and Nordic countries ($750 million).[26] The US announced a budget request of almost $1.7 billion for GFATM in 2014, the largest commitment of any country to the public-private partnership.[27] These commitments follow a $759 million pledge made by the Bill & Melinda Gates Foundation (BMGF) in 2012.[28]

Turning to other multilateral organizations, the WHO and other UN agencies essentially maintained the level of DAH disbursed. IHME's preliminary estimates show that the WHO's contribution dropped slightly, from $2.17 billion in 2012 to $2.15 billion in 2013, a 0.9% decrease. Underlying this reduction was the announcement of major shifts in the WHO's allocations across focal areas. Increases in expenditure on non-communicable diseases (20.5%) and preparedness, surveillance, and response (31.7%) offset a 51.4% cut in outbreak and crisis response and a 7.9% reduction in disbursements on communicable diseases.[29] IHME estimates of the DAH provided by UN agencies, including the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Pan American Health Organization, show growth of 3.6%, amounting to a combined total of $2.6 billion in 2013.

Finally, a large increase in the DAH provided by NGOs contributed to the sustained DAH total. In an effort to better track NGO spending, IHME produced estimates of both US-based and internationally based NGOs in 2013. Spending by US-based NGOs reached $4 billion in 2013, an increase of 1.8% from 2012. Spending

FIGURE 3

Change in DAH by channel of assistance, 1991–2000



Source: IHME DAH Database 2013

Notes: The bars represent changes in DAH in absolute and percentage terms from 1991 to 2000. On the vertical axis, channels are ordered by the magnitude of their contribution to the total change in DAH over this period.

by internationally based NGOs, which include NGOs based outside the US that receive some support from the US government, or otherwise report expenditure to the US, reached $895 million in 2013. These newly developed estimates reveal the slight contraction in internationally based NGO spending since 2012, as a 0.3% decrease was observed.

CHANGES IN CONTRIBUTIONS ACROSS PERIODS

Over more than two decades, three periods of growth in DAH can be distinguished: 1991–2000, 2001–2010, and 2011–2013. In the initial period of DAH highlighted (1991–2000), funding grew steadily and consistently, although less rapidly than in the subsequent timespan. From 1991 to 2000, total DAH grew by over $5.1 billion, with annualized growth of 7.3%. Across organizations, the World Bank's IDA and IBRD grew the most in absolute terms: $1.4 billion more in DAH was disbursed in 2000 than in 1991 by these institutions. The most substantial growth rate in this period was observed in UK bilateral assistance, which increased more than 25.8% in annualized terms during this time. With annualized growth of 22.3% and an absolute increase of $605 million, the strong growth of US foundations, shown in Figure 3, captures the launch of BMGF and the growing contributions of other private foundations. Over the same period, US bilateral assistance did not increase at rates comparable to later periods. Annualized growth amounted to 2.2%, an absolute increase of $179 million for US bilateral agencies.

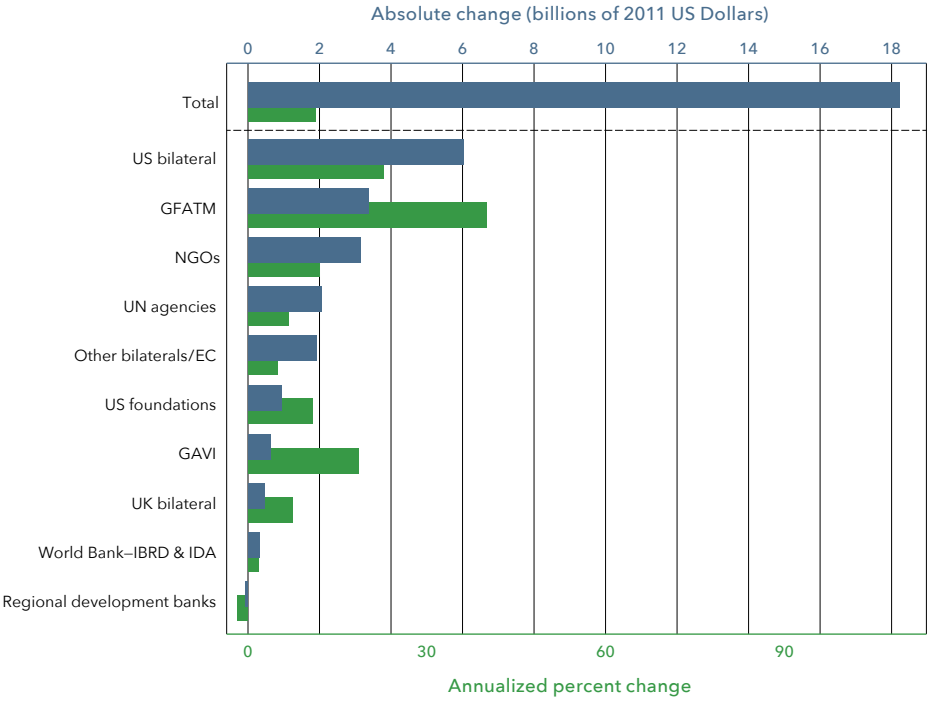
In contrast, the 2001–2010 period sets itself apart with extraordinary rates of growth. As shown in Figure 4, this period followed the launch of the Millennium Development Goals and the release of ambitious health-related targets. Rapid

FIGURE 4

Change in DAH by channel of assistance, 2001–2010

Source: IHME DAH Database 2013

Notes: The bars represent changes in DAH in absolute and percentage terms from 2001 to 2010, except for GFATM, which is relative to 2003. On the vertical axis, channels are ordered by the magnitude of their contribution to the total change in DAH over this period.



growth was largely driven by massive investments aimed at advancing these goals, including the fight against HIV/AIDS, malaria, tuberculosis, and child and maternal mortality, realized in the establishment of public-private partnerships.

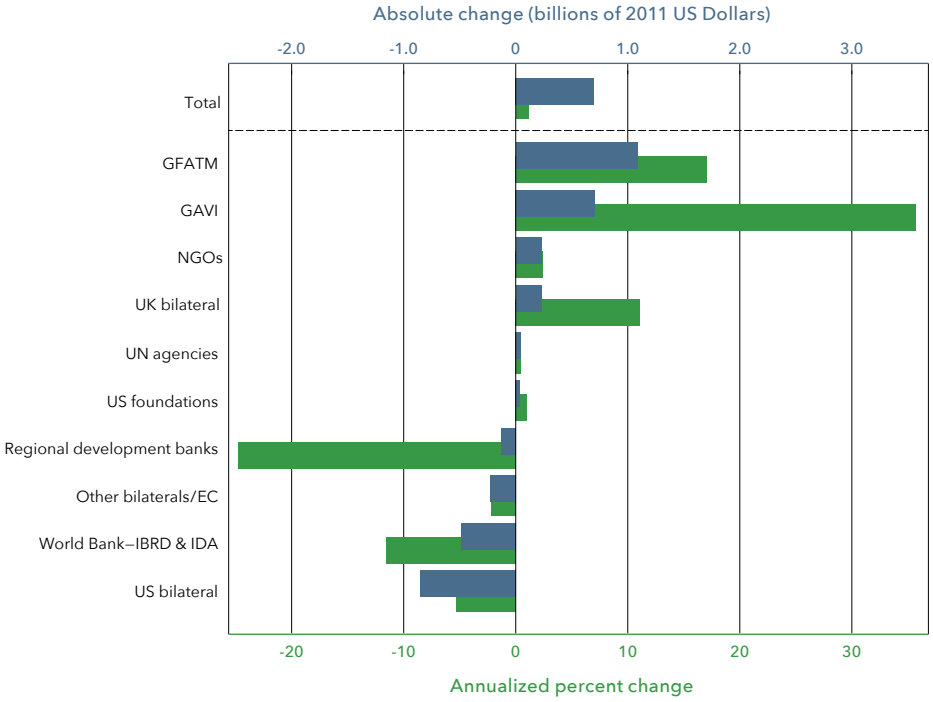
Figure 4 displays the much higher rates of growth that ensued over the 2001–2010 period. The most prominent increase was in US bilateral assistance. In addition to increased investments by the traditional US-based global health channels, such as the United States Agency for International Development (USAID), growth was also driven by the establishment of two organizations focused exclusively on infectious diseases: PEPFAR and the US President's Malaria Initiative.

Figure 4 also captures changes in multilateral contributions to DAH. The launch of GAVI and GFATM took place in this period. Due to their nascence on the global health stage during this time, their annualized growth rates are considerably high, at 40.1% and 18.6% for GFATM and GAVI, respectively. This contrasts with trends in the DAH provided by regional development banks. These entities were the only organizations to undergo reductions in DAH over 2001–2010, although the decrease, both in absolute ($57 million) and percentage terms (1.7%), was slight.

More recently, a mix of expansion and contraction has underpinned minor growth in total DAH, as shown in Figure 5. Increases continued to be led by investments focused predominately on communicable diseases. GAVI and GFATM grew considerably from 2011 to 2013. GAVI's rise during the 2011–2013 period is particularly impressive, with growth of 35.7% annually over 2011–2013, an increase of $708 million. GFATM's absolute increase is even higher, evidence of renewed support. Global Fund DAH increased by $1.1 billion between 2011 and 2013, with an annualized growth rate of 17.1%. Among bilateral agencies, the UK led in absolute ($231 million) and annualized growth (11.1%). The DAH provided by NGOs also expanded, with a $231 million absolute increase and 2.4% in annualized growth.

FIGURE 5

Change in DAH by channel of assistance, 2011–2013



Source: IHME DAH Database 2013

Notes: The bars represent changes in DAH in absolute and percentage terms from 2011 to 2013. On the vertical axis, channels are ordered by the magnitude of their contribution to the total change in DAH over this period.

Drops in expenditure were also observed. Falling substantially in percentage terms but minimally compared to DAH on the whole were the development banks. The trend across the African Development Bank (AfDB), the Asian Development Bank (ADB), and the Inter-American Development Bank (IDB) was a reduction of 24.8% in annualized terms over the period. This cutback amounted to $132 million. The largest absolute reduction in DAH, however, was observed in US bilateral contributions. The collection of US agencies that provide DAH decreased their spending by $857 million, a 5.3% drop in annualized terms.

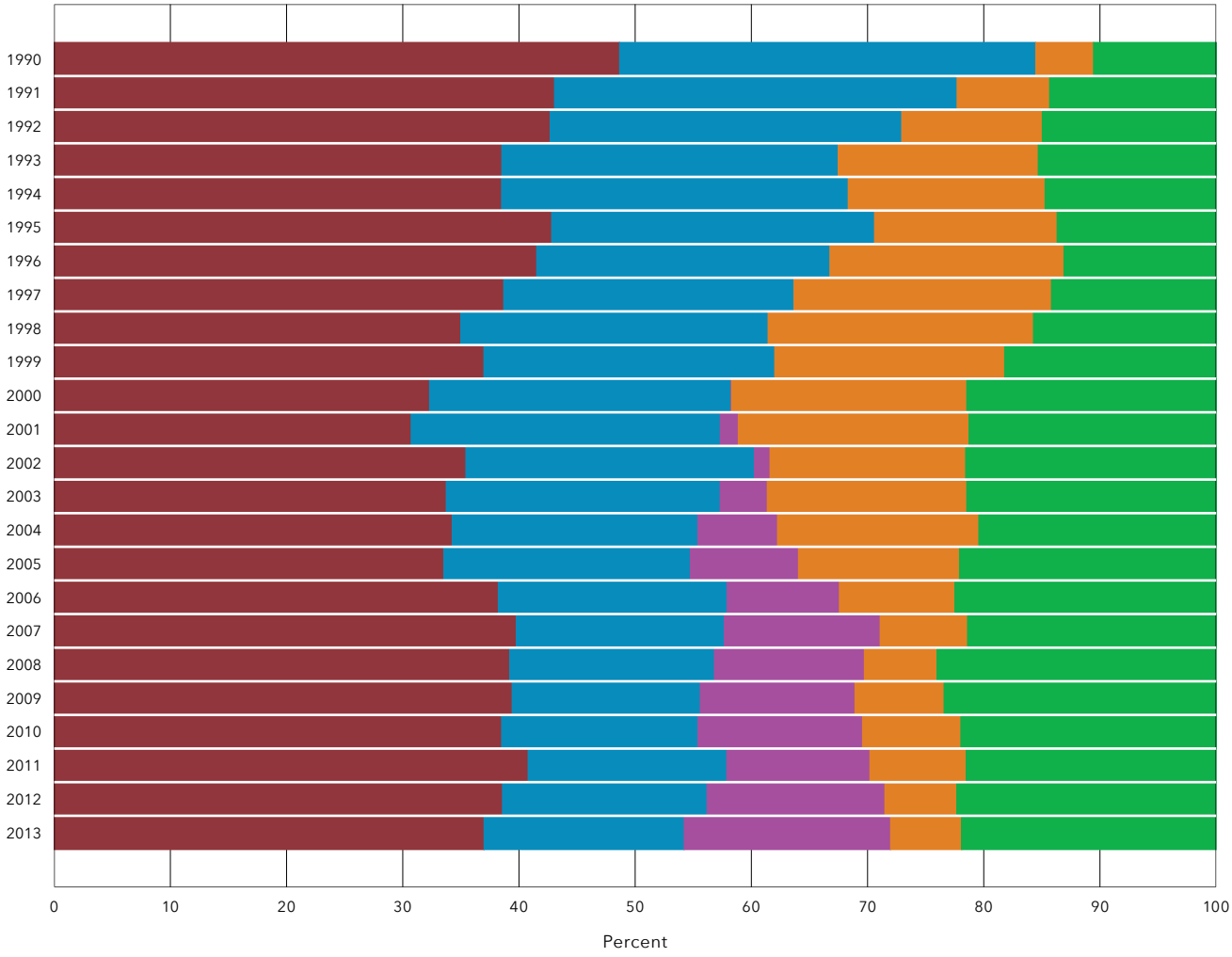
SHIFTS IN TYPES OF CONTRIBUTIONS OVER TIME

Public-private partnerships, bilateral agencies, UN agencies, NGOs, and development banks make up the main organizational typologies prominent in the field of development assistance for health. Each of these organizational types is subject to different pressures, capacities, and funding streams. These entities also target different health focus areas and deliver funds in unique manners. To explore transitions in the DAH landscape, Figure 6 aggregates channels into broader categories and displays the share of DAH each organizational type has contributed over time.

Figure 6 shows that the shares of DAH expended by NGOs and foundations, bilaterals, and public-private partnerships have changed substantially since 1990. In 1990, bilateral agencies channeled 48.7% of DAH. By 2013, preliminary estimates set their share at 37%. The portion of DAH provided by private foundations and NGOs has also risen consistently during this period. NGOs and private foundations provided 10.6% of funds in 1990. By 2013, these organizations were responsible for the disbursement of 21.9% of DAH. The launch of BMGF is a primary driver of this growth. Public-private partnerships, however, exhibit the most impressive growth in shares of DAH.

FIGURE 6

Changes in types of contributions, 1990–2013



Source: IHME DAH Database 2013

Since GAVI and GFATM were established at the turn of the century, they did not contribute to DAH in 1999. However, by 2013, these public-private partnerships together provided 17.8% of total DAH.

In contrast, the portion of DAH provided by UN agencies and development banks has declined since 1990. UN agencies spent 35.8% of all funds allocated to global health in 1990. By 2013, this had dwindled to 17.2%. Development banks have incurred the most substantial reductions in relative disbursements. At their peak in 1998, development banks contributed 22.8% of total DAH. By 2013, these entities provided only 6.1% of DAH. While these organizations continue to play a core function in the global health landscape, other types of structures are increasingly prevalent.