

Government health expenditure as a source

To complement its development assistance for health (DAH) time series, the Institute for Health Metrics and Evaluation (IHME) also annually produces estimates of government health expenditure as a source (GHE-S). The GHE-S series is estimated with use of the DAH data. The funds provided directly to developing country governments by development assistance partners are removed from GHE estimates. GHE-S thereby captures the funds governments in low- and middle-income countries contribute to health, as sourced directly from their tax base and other revenues. These estimates emphasize the fundamental role government financing plays in the provision of health services and public health intervention strategies in the developing world.

Examining GHE-S and DAH side by side reveals the current and growing prominence of GHE-S in health. GHE-S is consistently bigger than DAH by a wide margin. In 2011, GHE-S topped \$613.5 billion, which was 20 times greater than DAH in the same year. Furthermore, GHE-S growth is outpacing DAH, as the stagnation seen in DAH has not been present in GHE-S trends. Since 2008, annualized growth in GHE-S has amounted to 9.8%, while DAH's annualized rate over the same period was 6.4%.

Looking to regional trends, Figure 44 shows that governments in East Asia spend the most, absolutely, on health. In 2011, driven largely by the spending of the Chinese government, \$210.5 billion was spent in East Asia alone. Following East Asia was Latin America, where \$206.8 billion in GHE-S was spent in 2011. GHE-S in North Africa and the Middle East topped \$93.7 billion in 2011, a 3.5% increase over 2010. Despite the substantial disease burden afflicting most countries in sub-Saharan Africa, governments across all four Global Burden of Disease (GBD) regions spent just \$33.5 billion.

The change in governmental investments in health varies across regions. As shown in Figure 45, GHE-S either grew or held steady in all regions. East Asia grew the most in absolute (\$82.6 billion) and annualized (18.1%) terms between 2008 and 2011. Although GHE-S growth in most parts of sub-Saharan Africa was not as high as in other regions, annualized growth rates of more than 3% in West, East, and Southern sub-Saharan Africa amount to major increases in government spending. Andean Latin America showed almost no change during this period, with annualized growth of 0.1%.

Boosting governmental investments in health in sub-Saharan Africa has been on the global health agenda of late. Sub-Saharan African governments committed to health financing targets in Abuja in 2001, agreeing to provide 15% of general government expenditure for health. These targets were reiterated in Kampala in 2010 and in Addis Ababa in 2011 in an effort to further catalyze government investments in

FIGURE 44

GHE-S by Global Burden of Disease developing region, 1995-2011

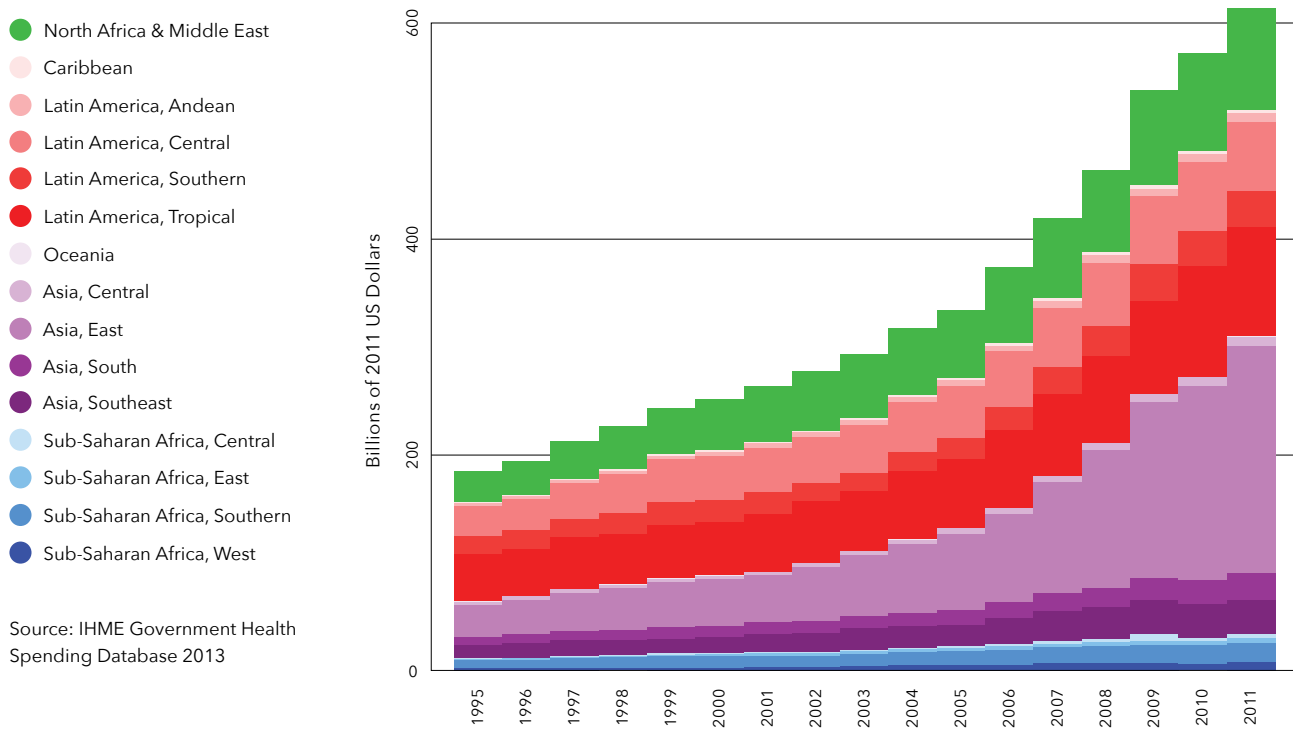


FIGURE 45

Change in GHE-S by Global Burden of Disease developing region, 2008-2011

Source: IHME Government Health Spending Database 2013

Notes: The bars represent changes in DAH in absolute and percentage terms from 2008 to 2011. On the vertical axis, channels are ordered by the magnitude of their contribution to the total change in government health spending over this period.

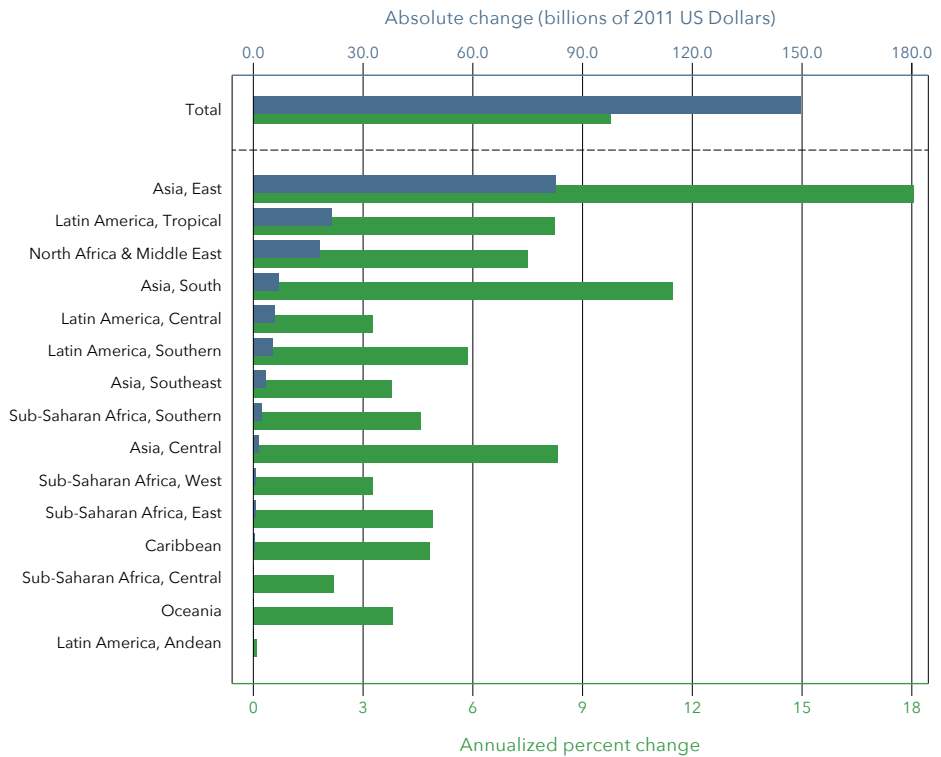
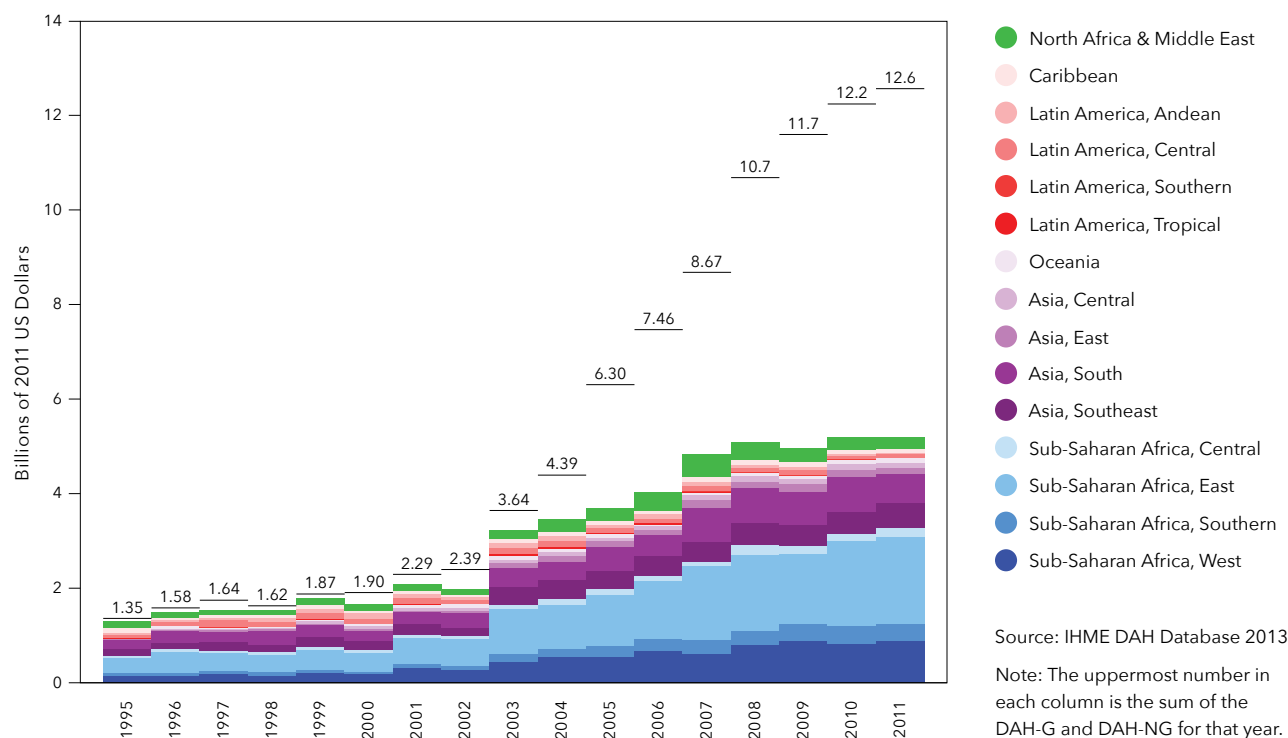


FIGURE 46

DAH-G by Global Burden of Disease developing region, 1995–2011



health.⁵⁶⁻⁵⁸ However, GHE as a share of total health expenditure reportedly grew in just 31 sub-Saharan African countries, while contracting in 13 across the region.⁵⁹

DAH FOR GOVERNMENTAL VERSUS NON-GOVERNMENTAL ENTITIES

Governmental and non-governmental entities play different roles in delivering health services and managing health systems. The split of DAH between governments and non-governmental entities (including private sector actors) has been shown to have an impact on government expenditure, as does the consistency of these flows over time.⁶⁰⁻⁶² For these reasons, IHME parses out the DAH provided to the non-governmental sector (DAH-NG) as compared to the DAH channeled to governments (DAH-G).

Governments have historically been the main recipients of DAH, as shown in Figure 46. From 1995 to 2001, 90% of DAH was funneled to governments. Since 2002, however, the share of DAH channeled to a recipient country’s government has diminished. From 2007 onward, in fact, DAH-G appears to have reached a stagnation phase. By 2011, DAH-G totaled \$5.2 billion.

Governments in sub-Saharan Africa received the largest share of DAH-G funds. In 2011, \$3.3 billion was provided to governmental agencies to spend on health. East sub-Saharan Africa alone received \$1.8 billion, while \$884 million was provided to West sub-Saharan African governments. The next-largest recipient was South Asia, which benefited from \$619 million in DAH-G in 2011. Southeast Asia, as well, received a substantial \$536 million in DAH-G.

FIGURE 47

DAH-NG by Global Burden of Disease developing region, 1995-2011

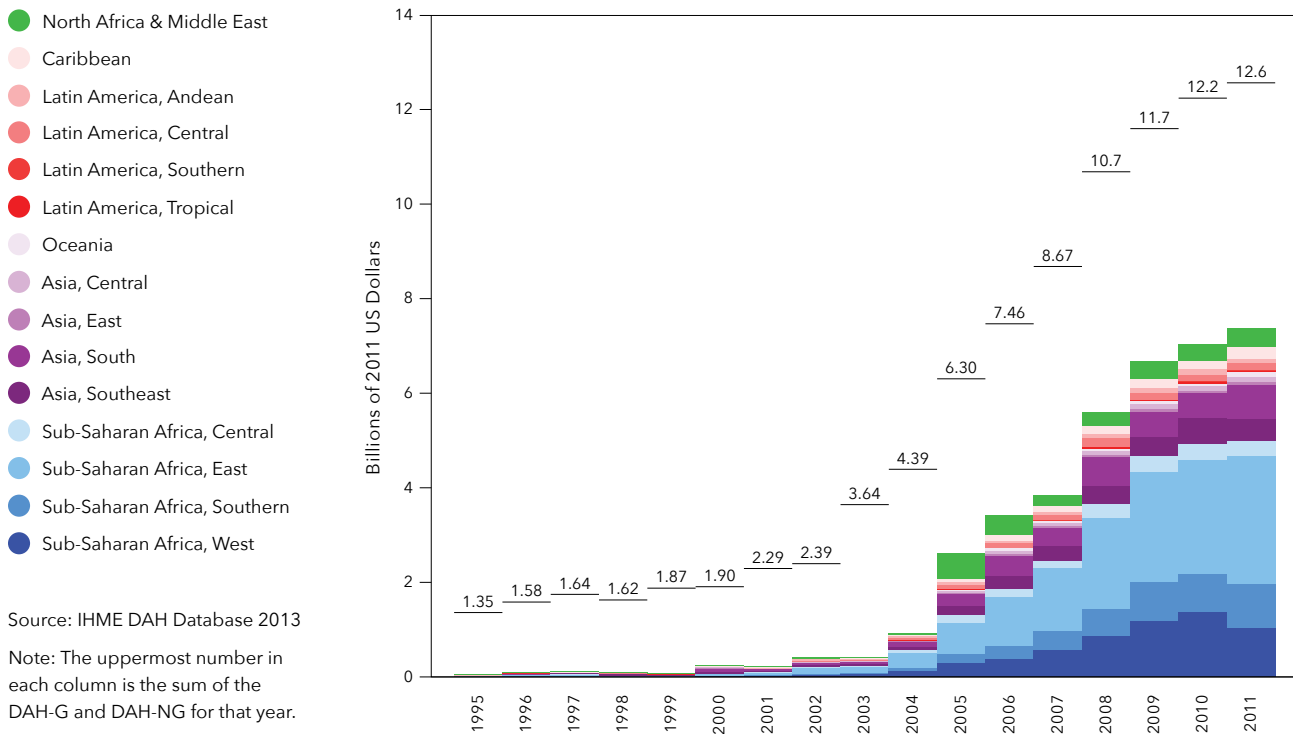
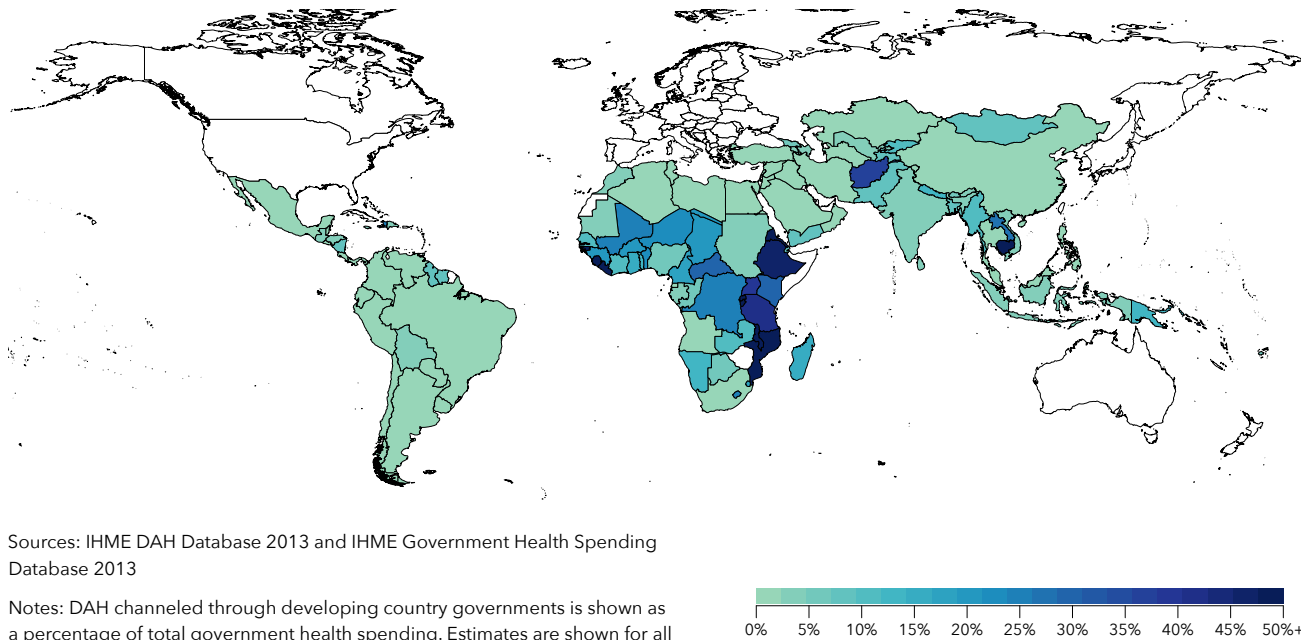


FIGURE 48

DAH-G as a percentage of government health expenditure, 2009-2011



In contrast, DAH-NG has risen sharply since 2003. Figure 47 shows that from 2003 to 2011, the rate of growth for DAH-NG was 43.5%. By 2011, total DAH-NG was \$7.4 billion. As a share of total DAH, DAH-NG was considerably higher than DAH-G. In 2011, DAH-NG accounted for 58.7% of total DAH.

Examining the regional distribution of funds shows that sub-Saharan Africa receives the majority of both DAH-NG and DAH-G. The region received 67.8% of DAH-NG and 63.2% of DAH-G in 2011. This is considerably larger than any other region's share of the two categories. Asia received 26.6% of DAH-G, or \$1.4 billion, and 18.3% of DAH-NG, a sum of \$1.3 billion, in 2011.

Across regions, the ratio of DAH-G to total GHE varies. Total GHE includes health spending from domestic and external sources. As Figure 48 shows, the DAH-G to GHE ratio is highest in select countries in sub-Saharan Africa. Among countries in this region, Mozambique, Malawi, Uganda, Guinea-Bissau, Sierra Leone, and Liberia receive some of the highest DAH-G as a share of GHE, amounting to upward of 50% in 2011. Looking to other regions, Cambodia also sources a large share of GHE from DAH to its government. Across South America and most parts of the Middle East, North Africa, and Asia, however, DAH-G's share of GHE is less than 5%.