# Conclusion

Updated estimates of development assistance for health (DAH) confirm that global health continues along a path of transition. At $31.3 billion in 2013, DAH climbed slightly over 2012. This is in line with recent trends, with DAH hovering just above $30 billion since 2010. Despite abounding reports of contractions in official development assistance, levels of DAH were maintained into 2013.

Underneath the bolstered total, emerging trends signal a pivot to different priorities. This year's edition of *Financing Global Health* highlighted the shifting role of income status, health focus areas, and delivery mechanisms in DAH. These changes emphasize the evolving and adaptable nature of the global health field.

Pairing Global Burden of Diseases, Injuries, and Risk Factors Study 2010 data with 2013 DAH estimates reveals an imbalance between DAH and disability-adjusted life years (DALYs). While the vast majority of DAH concentrates on communicable diseases, the leading causes of premature death and disability are shifting to non-communicable diseases (NCDs) in all regions with the exception of sub-Saharan Africa. The NCD burden is also rising quickly around the world. At the same time, a large burden of communicable, maternal, nutritional, and newborn diseases persists, especially in the poorest countries.

However, there are signs that DAH's substantial focus on HIV/AIDS, TB, and malaria may be shifting. The most rapidly growing health focus area from 2010 to 2011 was maternal, newborn, and child health (MNCH). MNCH posted a major rise in 2011, fueled by the push to address health issues faced by women and family planning efforts, as led by the Bill & Melinda Gates Foundation and the United Kingdom. NCD funding, while still a fragment of total DAH, also climbed. Reported increases by the World Health Organization and the attention brought to NCDs by consortiums of non-governmental organizations may fuel future expansion. Across the main infectious diseases, HIV/AIDS DAH increased slightly, while malaria and TB DAH fell.

*Financing Global Health 2013* also showed that the prominence of certain organizational types has shifted. Public-private partnerships have enjoyed a persistent, rapid expansion. These bodies are characterized by specialization in specific health focus areas and the influence of both public and private actors. Their rise has coincided with a decline in the share of DAH maintained by development banks.

The economic expansion of middle-income countries is also driving change in the DAH landscape. DAH to middle-income countries is being phased out by some Organisation for Economic Co-operation and Development governments. At the same time, these countries, including South Africa, China, India, and Mexico, are playing a growing role in DAH activities, in the form of technical cooperation, private investment flows, and the provision of development assistance.

As the developing world prepares for the post-2015 era, epidemiological, organizational, and economic transitions will continue to catalyze change in DAH disbursements. Improved information, such as the estimates produced by *Financing Global Health 2013*, will prove vital to development assistance partners as they make decisions about the causes and mechanisms to fund. With timely and comprehensive evidence in hand, stakeholders can work to improve population health in the developing world for generations to come.