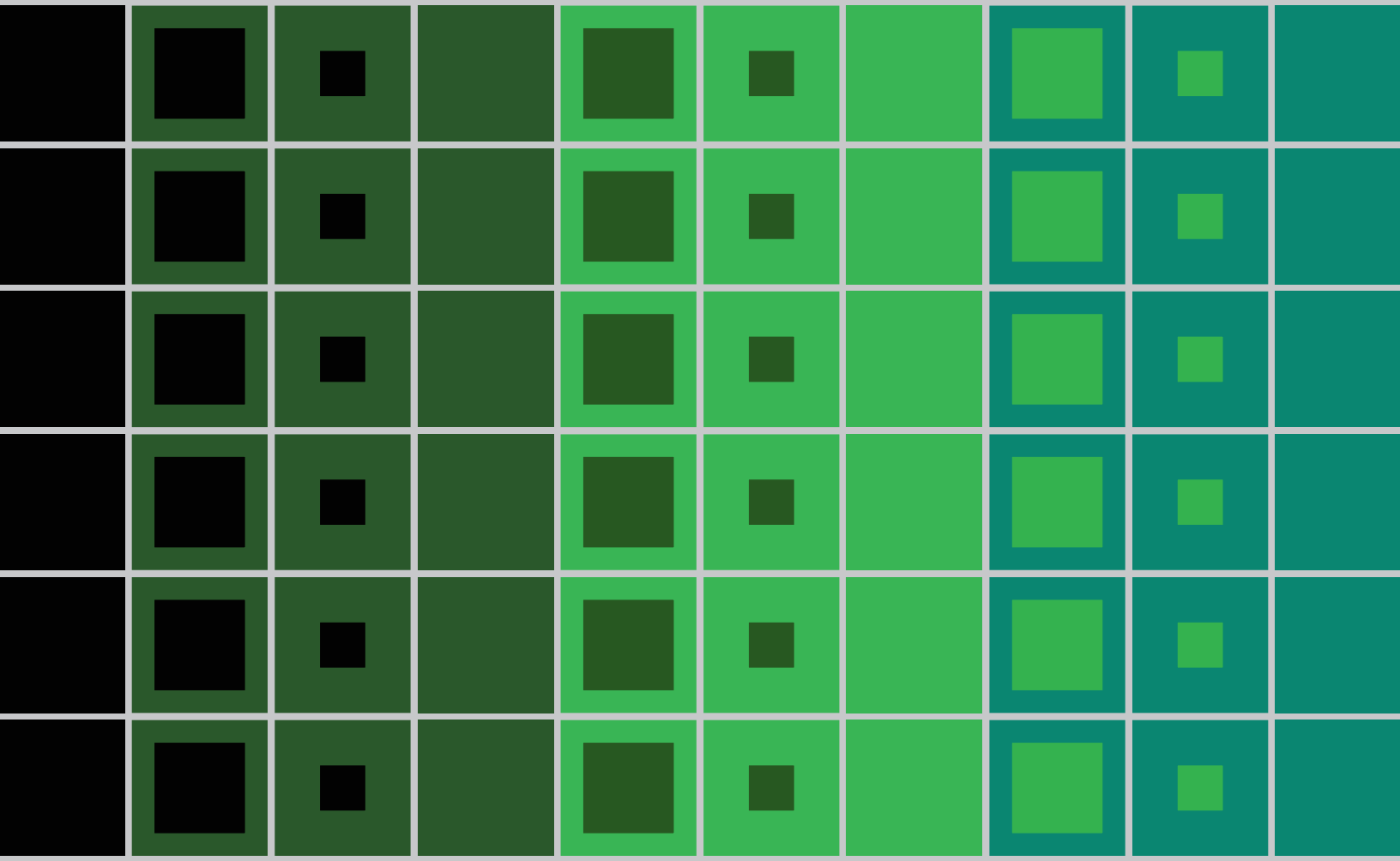
Financing Global Health 2013

Transition in an Age of Austerity



INSTITUTE FOR HEALTH METRICS AND EVALUATION
UNIVERSITY OF WASHINGTON

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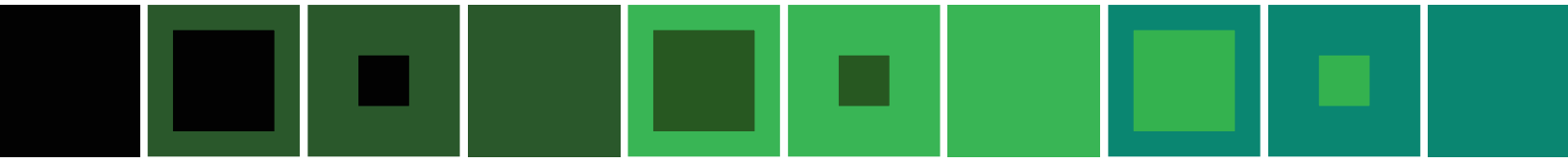

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ABOUT IHME

The Institute for Health Metrics and Evaluation (IHME) is an independent global health research center at the University of Washington. IHME provides rigorous and comparable measurement of the world's most important health problems and evaluates the strategies used to address them. As part of its mandate, IHME makes this information freely available so that policymakers have the evidence they need to make informed decisions about the allocation of resources to best improve population health. For more information, please visit http://www.ihmeuw.org.

ABOUT *FINANCING GLOBAL HEALTH 2013*

Financing Global Health 2013 is the fifth edition of this annually produced report on global health financing. As in previous years, this report captures trends in development assistance for health (DAH) and government health expenditure as source (GHE-S). Health financing is one of IHME's core research areas, and the aim of the series is to provide much-needed information to global health stakeholders. Updated GHE and DAH estimates allow decision-makers to pinpoint funding gaps and investment opportunities vital to improving population health.

This year, IHME made a number of improvements to the data collection and methods implemented to produce *Financing Global Health* estimates. Both government health expenditure and development assistance for health estimates were updated and enhanced in 2013.

- **Development assistance for health:** To develop DAH estimates, IHME collects data from organizations that provided funding for health projects in developing countries from 1990 through 2013. These data include annual reports, publicly available budgets, tax returns, and other information obtained through correspondence. Conversations with global health partners allow IHME to validate these data. Data are then processed into a form usable for analysis. This year's dataset is complete up until 2011 because a number of organizations are not able to produce budgetary documents until two years after the expenditure period. In cases where 2012 and 2013 data are not available, IHME uses statistical methods that rely on previous trends in spending and budget data to produce preliminary estimates.

- **Government health expenditure as a source:** IHME uses data produced by the World Health Organization (WHO) to provide estimates of GHE. Using DAH estimates, IHME employs the WHO's GHE data to approximate how much governments spend on health-related activities out of their own treasuries as well as how these expenditures vary over time.

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The IHME community contributed greatly to the production of this year's report. In particular, we thank IHME's Board for their continued leadership, Annie Haakenstad for writing the report, Casey Graves for data collection and analysis, William Heisel for editorial guidance, Adrienne Chew for editing, Patricia Kiyono for production oversight, Katherine Leach-Kemon for publication management, and Ryan Diaz for design.

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 the non-governmental sector
DALY	Disability-adjusted life year
DFID	United Kingdom's Department for International Development
DRC	Democratic Republic of the Congo
EC	European Commission
GAVI	The GAVI Alliance
GBD 2010	Global Burden of Diseases, Injuries, and Risk Factors Study 2010
GDP	Gross domestic product
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GHE	Government health expenditure
GHE-A	Government health expenditure as an agent
GHE-S	Government health expenditure as a 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
IHME	Institute for Health Metrics and Evaluation
MDGS	Millennium Development Goals
MNCH	Maternal, newborn, and child health
NCD	Non-communicable disease
NGOS	Non-governmental organizations
OECD	Organisation for Economic Co-operation and Development
PAHO	Pan American Health Organization
PEPFAR	United States President's Emergency Plan for AIDS Relief
SWAPS	Sector-wide approaches
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
WHO	World Health Organization

FIGURES AND TABLES

Executive summary

The global health financing trends depicted in *Financing Global Health 2013: Transition in an Age of Austerity* underline the resilience of development assistance for health (DAH). The updated estimates produced by the Institute for Health Metrics and Evaluation (IHME) show that despite lackluster economic growth and fiscal cutbacks in many Organisation for Economic Co-operation and Development (OECD) countries, total DAH remained steady in 2013. Preliminary estimates set DAH at an all-time high of $31.3 billion in 2013.[i] With 3.9% growth from 2012 to 2013, the year-over-year increase falls short of the rapid rates seen over 2001–2010, which topped 10% annually. However, DAH has hovered above more than $30 billion annually since 2010. The maintenance of substantial levels of international funding is a sign of the international development community's enduring support for global health as the deadline to attain the Millennium Development Goals (MDGs) nears.

This year's report unveils new perspectives on the data that emphasize shifts in the prominence of DAH partners. Bilateral aid agencies on the whole have reduced their DAH contributions, and their share of DAH has diminished since 2011. In addition, contributions from the World Bank's International Bank for Reconstruction and Development peaked in 2010. Over the same period, the major public-private partnerships, notably the GAVI Alliance (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), continued to expand, sustaining health assistance at current levels. Growth in DAH from non-governmental organizations (NGOs), especially those based in the United States, has also helped offset declines in spending by other development actors. The growing role of public-private partnerships and NGOs, coupled with contraction in bilateral agencies and development banks, entails shifts in the modes of DAH delivery.

Epidemiological data also enhance updated estimates of DAH. Pairing DAH with disability-adjusted life years (DALYS) reveals imbalances between disease burden and international investments. Non-communicable diseases (NCDs), while a prominent and rising portion of disease burden in the developing world, are not a primary focus of DAH. However, DAH for non-communicable diseases did expand from 2010 to 2011. The DAH allocated to maternal, newborn, and child health (MNCH) also grew substantially, reflecting donors' continued support for the unfinished agenda of MDGs 4 and 5, which aim to reduce child and maternal mortality. Concurrently, the DAH disbursed in the fight against the main infectious diseases, HIV/AIDS, tuberculosis (TB), and malaria, contracted on the whole. Health focus area estimates highlight a minor shift away from communicable disease spending on HIV/AIDS, TB, and malaria within total DAH.

A host of enhancements have improved this year's dataset while ensuring methodological continuity across previous editions of the report. Estimates of spending by each of the main development assistance partners, health focus areas, and geographical units have been fine-tuned. Newly developed methods track

i All dollar figures in this report are provided in 2011 US dollars.

spending from NGOs based outside of the US, parse out the DAH provided to tobacco control, and elucidate the allocations of non-governmental organizations across health focus areas.

The key findings of *Financing Global Health 2013: Transition in an Age of Austerity* include the following:

Development assistance for health

- According to IHME's preliminary estimates, total DAH in 2013 amounted to $31.3 billion. The year-over-year increase in DAH was 3.9%.
- While the United States continued to be the single largest channel of DAH, at $7.4 billion, 2013 marks the second consecutive year of reduction in DAH from the US. US DAH peaked in 2011 at $8.3 billion.
- Although the United Kingdom is recalibrating the countries and health areas it targets, the DAH disbursed by the UK continued to rise in 2013. DAH from the UK amounted to $1.2 billion in 2013, a 24.7% increase over 2012 disbursements.
- The spending of public-private partnerships also grew substantially in 2013. GAVI's disbursements reached an estimated $1.5 billion in 2013, a 32% increase relative to 2012 levels. GFATM grew 16.8%, with 2013 DAH expenditure of $4 billion.
- DAH from NGOs increased by 2.4% between 2011 and 2013. Of the NGOs IHME can track, those based in the US spent $4 billion in 2013, while NGOs based outside the US spent $895 million that same year.
- Across regional groupings, sub-Saharan Africa received the largest portion of DAH. In 2011 (the most recent year for which recipient-level estimates are available), sub-Saharan Africa's share was $8.8 billion, or 28.6% of total DAH.
- The HIV/AIDS sector was the beneficiary of the most substantial share of DAH among health focus areas in 2011 (the most recent year for which focus area estimates are available). HIV/AIDS assistance amounted to $7.7 billion in 2011. This was a 1.2% increase from 2010.
- The share of DAH targeting maternal, newborn, and child health continued to grow. In 2011, MNCH received $6.1 billion, a 17.7% increase from 2010.
- IHME's updated estimates of DAH also show that non-communicable diseases and tobacco control received little funding, particularly as compared to the major portion of burden of disease associated with these health issues. In 2011, a total of just $377 million was provided in the fight against NCDs, while $68 million was channeled to tobacco-related programs.
- Many of the countries with the highest disease burdens do not receive the most DAH. Of the countries with the top 20 DALYs, only 13 are among the top 20 recipients of DAH.

Government health expenditure as a source

- Spending by governments on health as sourced domestically (GHE-S) was $613.5 billion in 2011. This means that, on average, countries spent 20 times more of their own resources on health than they received in assistance. Furthermore, government health spending grew at a faster pace than assistance. This spending grew 7.2% from 2010 to 2011 (the most recent year for which estimates are available).
- The amount of total health spending represented by DAH varied widely by country. The share of DAH funneled to governments (DAH-G) as a part of total

spending by governments on health was typically less than 10%. However, in certain countries in Asia and Western and Southern Africa, DAH channeled to governments amounted to more than half of total government health expenditure.

Overall, while many OECD countries are still grappling with stunted economic growth, health assistance has not radically contracted, emphasizing the high priority numerous global health stakeholders place on global health. The enduring level of DAH and the shifts in composition emphasize the importance of tracking these financial flows. Timely and comprehensive estimates of DAH provide information vital to informed decision-making by donors, policymakers, and health practitioners alike.

BOX 1

Putting development assistance for health in context

- **Development assistance for health: relatively small but growing.** Donors disbursed a total of $31.3 billion to improve health in low- and middle-income countries in 2013. This is more than five times larger than the development assistance for health provided in 1990. However, this is also less than 1% of what developed countries spent on improving and maintaining the health of their own countries.[ii]

- **Support for the most vulnerable.** Assistance for maternal, newborn, and child health reached $6.1 billion in 2011. Funding for this area increased more than any other between 2009 and 2011. However, maternal, newborn, and child health spending per live birth remains just $51.[iii]

- **Non-governmental organization contributions as a key catalyst.** Since 1990, NGO global health expenditure has grown 11% annually, at points outpacing total development assistance for health. NGO contributions span all areas of global health. NGOs also spend more annually than any one of the major multilateral agencies.

ii Government health spending data are derived from the WHO, available at http://www.who.int/nha/en/.

iii Live births were estimated as part of the Global Burden of Disease Study 2010. For more information, visit http://www.ihmeuw.org/gbd.

Introduction

In the wake of the financial crisis, governments have scrutinized spending across their fiscal space. Development assistance is often one of the first items discussed for the budgetary chopping block.[1-5] Nevertheless, the Institute for Health Metrics and Evaluation's (IHME) estimates show development assistance for health (DAH) continues to grow. In fact, DAH reached the highest level ever recorded in 2013. While the most recent increases fall short of the rapid growth rates observed over 2001–2010, a year-over-year increase persisted in 2013. The enduring provision of DAH during a time of fiscal constraint is testament to the international community's solid commitment to global health.

DAH is also increasingly marked by transition. Sources and recipients of DAH have shifted in recent years. Levels of spending have been maintained by a number of key actors, notably the United Kingdom, non-governmental organizations, and public-private partnerships. The contributions of other development assistance partners have not grown substantially and in some cases have contracted. Additionally, weighing priorities in a constrained resource environment has led some Organisation for Economic Co-operation and Development countries to reduce or phase out DAH to middle-income countries, despite the hefty disease burdens and large, impoverished populations present in these areas.

The international community's focus on the next epoch of global health is also a sign of its resolve to maintain DAH. With the conclusion of the Millennium Development Goals (MDGs) approaching, a new set of broad goals and measurable targets was prominent in high-level discussions about global health throughout 2013. While it is difficult to determine causation, a rapid rise in DAH followed the establishment of the MDGs. The health interventions associated with MDGs 4, 5, and 6 continue to be the focus of the international community, and development assistance for HIV/AIDS and maternal, newborn, and child health sustained growth through 2011. Regardless of the outcome of the post-2015 discussions, it is likely that the targets established will shape priorities in DAH in the coming decade.

Replenishment activities punctuated the 2013 global health landscape and signaled continued support for DAH. The Global Fund to Fight AIDS, Tuberculosis and Malaria put the final touches on its new funding model and has already received pledges of support to continue its work. The World Bank's International Development Association also convened development assistance partners to successfully raise financial support for its lending activities.

Finally, better information about the burden of disease emphasizes the impact of the epidemiological transition to non-communicable diseases in the developing world. In 2013, IHME built upon the Global Burden of Diseases, Injuries, and Risk Factors Study 2010 methods and data. New findings published across a number of academic journals highlighted the growing burden of non-communicable diseases.[6-8]

This shifting global health landscape informed enhancements to this edition of *Financing Global Health*. This year, IHME focused on improving estimates of DAH by channel and refining health focus area allocation methods. IHME substantially reduced the "other" and "unallocable" categories and added a new health focus

area: tobacco control. IHME also now splits up non-governmental organization funding into health focus areas, further improving the estimates of funds allocated to distinct global health activities.

This edition of *Financing Global Health* is structured to emphasize improvements to the methods and data as well as the stories and figures that highlight evolving global health funding flows. Chapter 1 focuses on macro trends in DAH, featuring changes in the most prominent channels and shifts in the distribution of types of channels over time. In Chapter 2, we focus on recipient countries and the DAH they received. Chapter 3 delves into the types of interventions and activities typically supported by DAH, as distinguished by diseases, certain risk factors (tobacco use), and health sector support. Chapter 4 concentrates on the origin of funds and the composition of their support across time, income, and organizations. Finally, Chapter 5 features IHME's estimates of government health expenditure, a less discussed but nonetheless vital component of global health financing.