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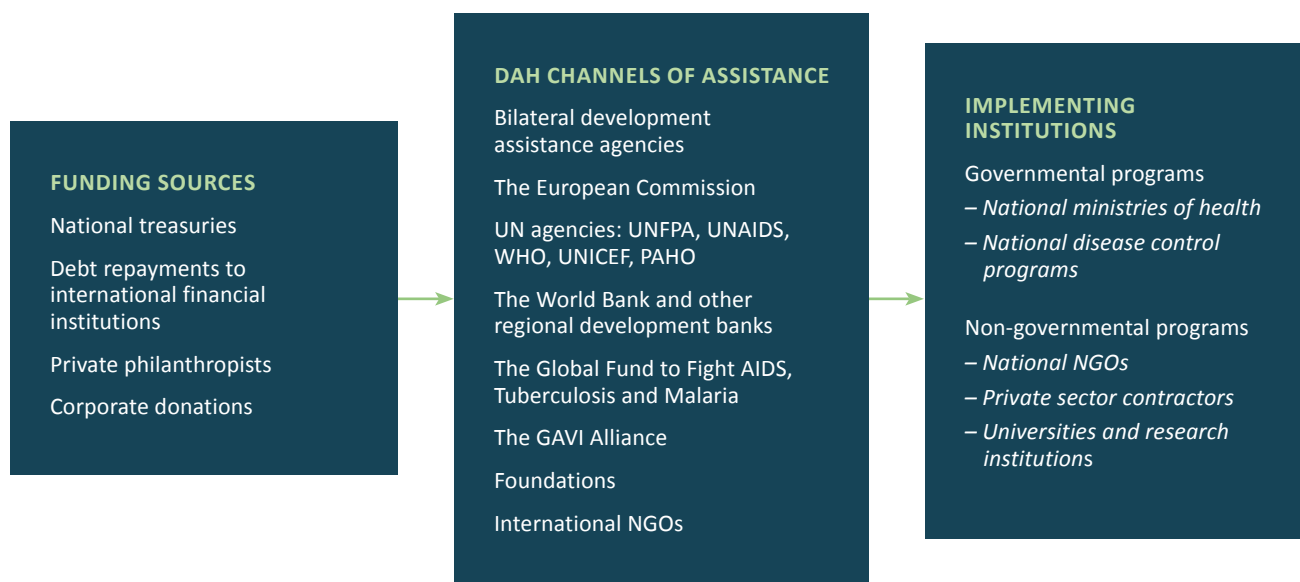
OVERVIEW OF DEVELOPMENT ASSISTANCE FOR HEALTH TRENDS

Since the inception of the first edition of *Financing Global Health* in 2009, IHME has released up-to-date annual estimates of DAH from 1990 onward. This chapter relies on these estimates, including preliminary estimates for 2011 and 2012, to explore trends in DAH over the last two decades. The evolution of growth in DAH, as will be shown, varies from broader trends in official development assistance (ODA).

To facilitate the tracking of DAH, IHME utilizes a framework that identifies the entities involved in different steps of the transfer of DAH from source to recipient countries. Figure 1 represents this flow of funds. Isolating actors in this manner allows IHME to eliminate

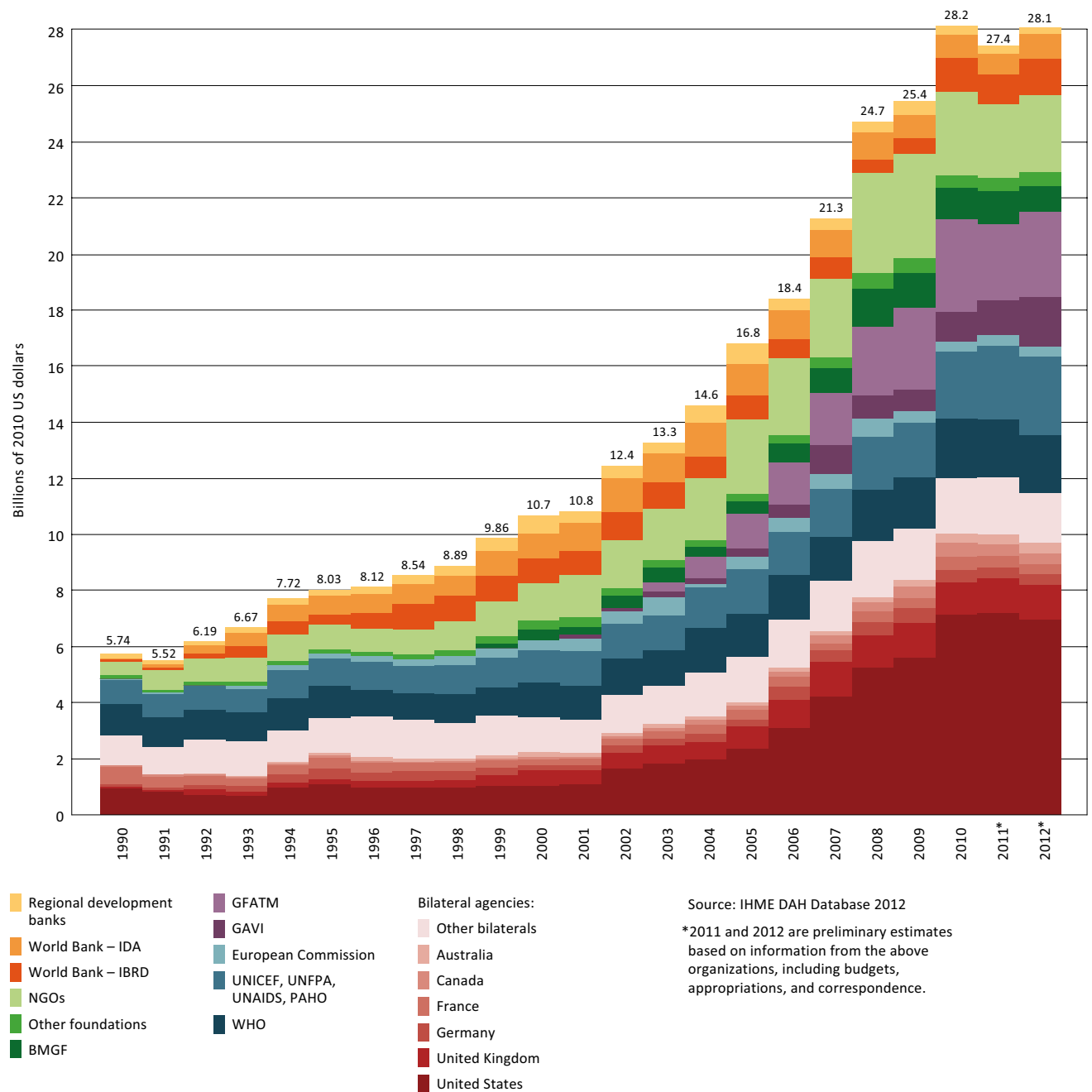
any double counting among resource flows.ⁱⁱ Sources constitute the origin of the financial resources available for DAH, and include national treasuries and private donors in developed countries and loan repayments by governments in developing countries. These resources are transferred through channels of assistance such as bilateral and multilateral development assistance entities, United Nations (UN) agencies, non-governmental organizations (NGOs), and development banks. These actors serve as intermediaries in the resource chain. Finally, IHME identifies implementing institutions as the governmental organizations or NGOs that execute programs to ameliorate health at the country level. A complexity of this framework is that, in some cases,

FIGURE 1:
Resource flows for DAH



ⁱⁱ To produce estimates for each channel, funding that originates in one channel but flows through another is subtracted from the first. For example, funding from Germany that flows through GAVI would be subtracted from the total DAH counted as provided by Germany but would be included in the total for GAVI.

FIGURE 2:
DAH by channel of assistance, 1990-2012



channels may also serve as implementing institutions. When a UN agency such as the World Health Organization (WHO) runs a polio-eradication campaign, for example, it is acting as both a channel and an implementing institution.

DAH by channel of assistance

After two decades of consistent growth, our preliminary estimates show that DAH peaked in 2010. The

Financing Global Health 2012 estimates reveal that DAH reached a historic high of \$28.2 billion in 2010, but fell in 2011 for the first time since DAH could be tracked. As shown in Figure 2, total DAH amounted to \$27.4 billion in 2011. This could be a short-term trend, as our preliminary 2012 estimates indicate a slight uptick from 2011, with DAH increasing to \$28.1 billion. However, projections for further cutbacks in development assistance do not augur well for a return to the rapid growth that punctuated the 2001 to 2010 era.

Examining growth in DAH since 1990 reveals three clear trends. From 1990 to 2001, DAH was marked by consistent but modest rates of growth. Annualized growth was 5.9% during this “moderate-growth” period. In 2001, however, DAH entered a period of “rapid growth.” From 2001 to 2010, growth proceeded at a very strong pace of 11.2% in annualized terms. Finally, our preliminary estimates suggest that DAH passed into a “no-growth” phase starting in 2010, with total DAH wavering around \$28 billion. DAH decreased less than 0.1% in annualized terms from 2010 to 2012.

Our 2011 and 2012 estimates of DAH correspond with the evolving response of OECD countries to the global financial crisis. Traditional development assistance partners, particularly in Europe, are adjusting to new fiscal and economic realities. As a result, bilateral aid agencies are being asked to tighten their budgets. Our preliminary 2012 estimates of DAH reflect these circumstances: On the whole, the DAH provided by bilateral agencies dropped 4.4% from 2011 to 2012. Among the six bilaterals contributing the most to DAH, aid from France dropped most substantially. Although French DAH fell 13% from 2011 to 2012, French bilateral spending nevertheless amounted to \$352 million in 2012. The drop in German DAH was the second most significant, with a 9.1% decrease. Even so, Germany persisted in contributing \$370 million of DAH through the end of 2012. Canada’s DAH also dropped 5.7% to \$379 million in 2012. Finally, DAH from the biggest source, the United States, fell 3.3%, disbursing \$7 billion of DAH in 2012.

Reductions in DAH did not occur uniformly across bilateral agencies. In fact, certain bilateral partners provided more DAH in 2012 than in 2011. The United Kingdom, because of a national decision to prioritize development assistance,^{14,15} stands out among European countries for its commitment to DAH. The UK’s DAH rose 2.3% to \$1.3 billion in 2012. Australia, which has weathered the global financial crisis fairly well,¹⁶ also contributed more DAH in 2012. Australia spent approximately \$407 million in 2012, an 8.1% gain over 2011.

Likewise, the trends in DAH varied among different multilateral organizations. On the whole, the UN agencies providing support to health and health systems continued their steady and consistent rise. UN DAH grew 3.4% in 2012. However, expenditure by the WHO fell 2% in 2012; total WHO disbursements amounted to only \$2.1 billion in 2012. This drop was offset by increased expenditure from other UN organizations included in our estimates, such as the United Nations

Children’s Fund (UNICEF) and United Nations Population Fund (UNFPA), which expanded by approximately 7.5%, to a total of \$2.8 billion in 2012.

Since 2000, public-private partnerships have played a key role in the global health field. GAVI continued to grow rapidly through 2012, as DAH disbursements increased to \$1.8 billion, a year-over-year change of 41.9%. GFATM, on the other hand, has not enjoyed the same level of support in recent years. In 2011, GFATM spending dropped 17% from 2010. GFATM recovered some of that loss in 2012, increasing by an estimated 12.3%. Despite this mild recovery, GFATM’s expenditure in 2012 remained below its 2010 peak of \$3.3 billion. Total GFATM spending in 2012 reached just under \$3.1 billion. The launch of a new GFATM funding model was announced in 2012, as the organization is entering a new replenishment period. This may have an effect on future spending, as it is anticipated to increase transparency and accountability as well as enhance GFATM’s impact.¹⁷

Different lending institutions also engage in disbursements that we consider to be DAH. With new leadership at its helm and a renewed focus on human development,¹⁸ the World Bank grew significantly in 2012, according to our preliminary estimates. In 2012, \$1.3 billion was disbursed by the World Bank’s International Bank for Reconstruction and Development (IBRD). The IDA arm of the World Bank spent just slightly less at \$912 million, according to our 2012 preliminary estimates. Both IDA and IBRD grew approximately 22% year over year. IDA, notably, will also embark on a new replenishment cycle in 2013, underpinned by a shrinking pool of eligible countries.

In contrast to the World Bank, regional banks did not exhibit growth from 2011 to 2012. Lending by these entities, which disburse DAH on a regional basis and include the African Development Bank, the Asian Development Bank, and the Inter-American Development Bank, decreased 17.2% from 2011 to 2012. They distributed just over \$234 million in 2012.

The contributions made by foundations to DAH also shifted from 2011 to 2012. The Bill & Melinda Gates Foundation (BMGF) contributed an estimated \$899 million of DAH in 2012. As with all the channels, funds are only assigned once to avoid double counting; BMGF contributions to UNICEF, for example, are deducted from BMGF’s total because they are included in UNICEF’s total. After removing DAH that would have been double counted, BMGF’s DAH fell in 2012. DAH disbursements by all other foundations in 2012

amounted to \$511 million. This was an increase of 5.3% over 2011.

Finally, IHME tracks the DAH expended by US NGOs. While providing estimates of all NGO spending would be ideal, data on these organizations are sparse, particularly for entities operating outside the US. Therefore, IHME has not yet been able to generate refined estimates for this category of DAH. US NGOs suffered severe cutbacks during the 2009 to 2010 period, falling more than 20%. Contrary to expectations, this trend did not continue into 2012. In 2012, NGOs maintained their share of expenditure. The DAH distributed to NGOs amounted to \$2.7 billion in 2012, a 4.3% increase from 2011. While NGO DAH has not been restored to its peak of \$3.7 billion in 2009, the 2012 DAH numbers exhibit a minor bounce-back in US NGO spending.

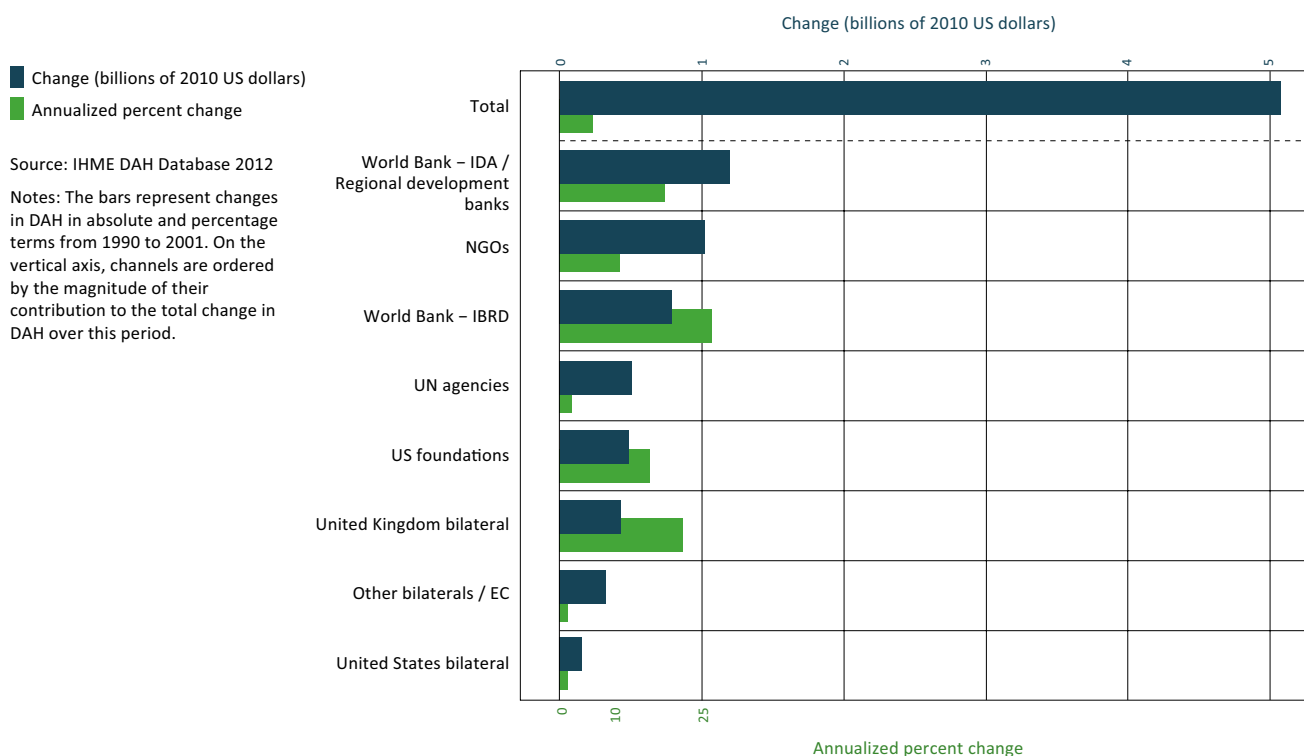
In an effort to ensure that we produce the most accurate estimates possible, the information used to produce the preliminary estimates is updated every year. For this reason, the preliminary 2010 and 2011 estimates, as reported in *Financing Global Health 2011*, have changed slightly in the 2012 edition because new information came to light that helped to refine them. In

this edition, the 2010 estimate of total DAH has been adjusted from \$26.7 billion to \$28.2 billion. The 2011 estimate was also revised from \$27.7 billion to \$27.4 billion. These adjustments were driven by a number of factors, most importantly by new information about the disbursements made by the World Bank’s IBRD. IBRD responded more swiftly to the financial crisis than expected, disbursing large sums of DAH through its fast-acting Development Policy Loans. As a result, funds that we initially forecasted to be disbursed in 2011 and beyond were actually disbursed in 2010. Spending by IDA, UNICEF, and NGOs was also higher than expected in 2010.

The “moderate-growth” phase

From 1990 to 2001, DAH grew at a moderate but consistent rate of 5.9% on an annualized basis, as displayed in Figure 3. This “moderate-growth” phase took place, however, as total ODA stagnated. According to the OECD, ODA dropped almost \$7 billion between 1990 and 2001.¹⁹ While DAH and ODA are not entirely comparable (DAH includes the contributions of NGOs and private foundations), over that same period, total DAH nearly doubled.

FIGURE 3:
Change in DAH by channel of assistance, 1990-2001



During this period, DAH was driven up by \$5.1 billion in spending by a number of actors, most predominantly by the World Bank’s IDA and the regional development banks. These entities grew a combined \$1.2 billion or 18.6% annually. NGOs also expanded their DAH spending considerably in absolute terms, growing by \$1 billion. With the establishment of BMGF and other philanthropic organizations, US foundations’ DAH spending jumped 15.9%, with contributions rising just under \$484 million. The UK’s bilateral DAH enlarged substantially in annual percentage terms (21.7%), growing by \$434 million.

The “rapid-growth” phase

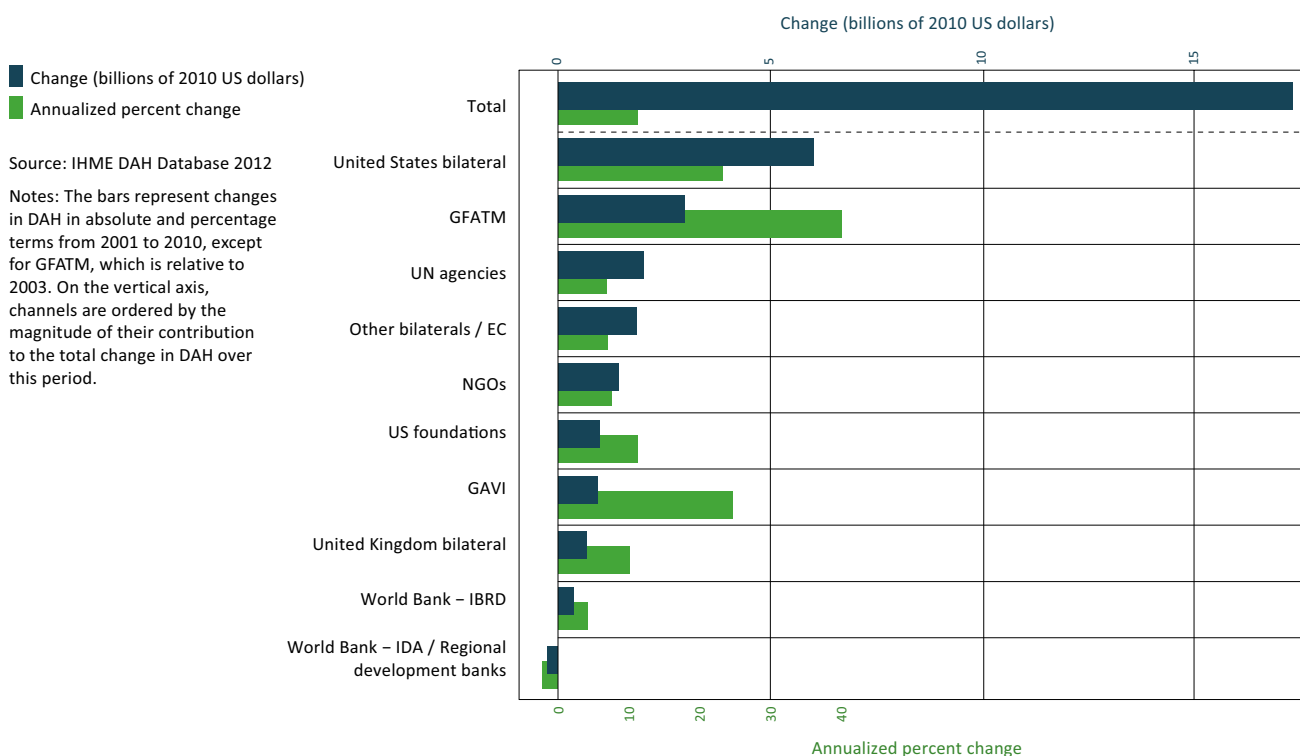
Over the course of the “rapid-growth” phase, DAH grew at a strong 11.2% on an annualized basis, increasing by \$17.3 billion from 2001 to 2010. Development assistance partners also expanded their support for wider ODA during the same period. ODA rose from \$92.2 billion in 2001 to \$148.4 billion in 2010, as displayed in Table 1 (on page 18). However, the consistently sizeable pace of growth in DAH demonstrates the serious commitment of development assistance partners to addressing health issues afflicting the developing world.

Around the turn of the 21st century, a flurry of activity focused on global health issues, catalyzing a “golden age” of increases in DAH. At the Millennium Summit in 2000, UN members launched the MDGs, three of which focus directly on health. Also in 2000, at the Group of Eight (G8) Summit in Okinawa, Japan, G8 governments noted that six diseases, including HIV/AIDS, TB, and malaria, were the main causes of death worldwide and prioritized combating them.²⁰ Finally, over the course of the three years that followed, a number of crucial global health organizations, including the US President’s Emergency Plan for AIDS Relief (PEPFAR), GFATM, GAVI, and others were created, entailing the commitment of substantial amounts of funds to their objectives and operation.

Among the organizations that took off during this period, public-private partnerships underwent the most substantial expansion. Funding for GAVI, created in 2000, and GFATM, launched in 2002, rose significantly as DAH entered its rapid-growth phase. GFATM increased 40.2% on an annualized basis from 2003 until 2010. GAVI realized an annualized growth rate of 24.7% from 2001 to 2010.

Similar growth occurred in spending on DAH by bilateral and multilateral aid agencies. The US contributed

FIGURE 4:
Change in DAH by channel of assistance, 2001-2010



34.8% to the total annual rise in DAH spending. This amounted to \$6 billion in increased US DAH and annualized growth of 23.2%. The UK increased its DAH by 10.1% in annualized terms (\$678 million). Other bilaterals, including the European Commission (EC), expanded 7% annually, a rise of \$1.9 billion from 2001 to 2010. With respect to development banks, however, rates of growth were mixed. The World Bank’s IBRD increased (4.1%) during this time.

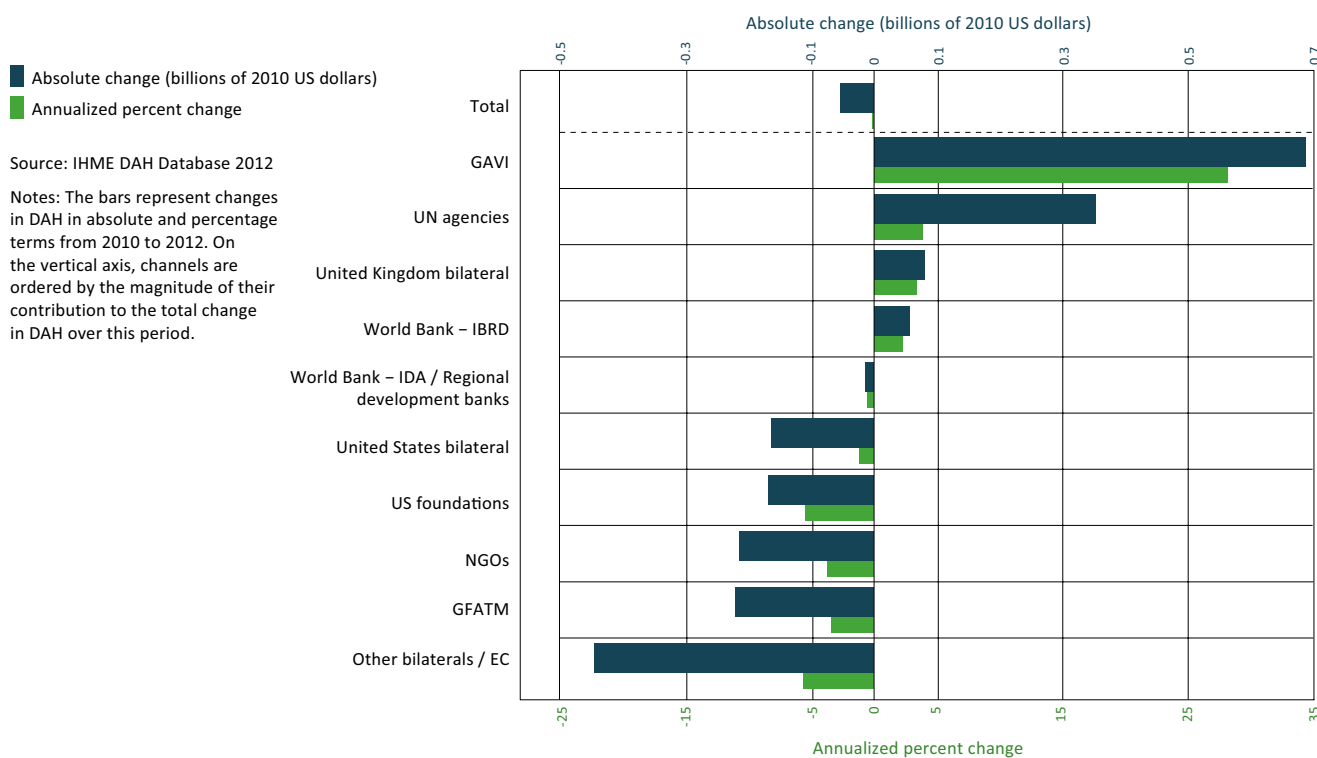
It is also during this rapid-growth period that actors outside of traditional bilateral and multilateral circles began to take on a more prominent role in disbursing DAH. The largest foundation now in operation, BMGF, contributed significantly to DAH as the field expanded from 2001 to 2010. BMGF was formally established in 1999 and grew rapidly from its inception onward. US foundations, including BMGF and other private foundations, increased \$974 million with an 11.3% annualized growth rate from 2001 to 2010. NGOs also expanded rapidly as they took on an increasingly prominent role in supporting health systems across the developing world during this period. Spending by NGOs (predominantly US organizations) climbed \$1.4 billion with growth of 7.6% in annualized terms from 2001 to 2010.

The “no-growth” phase

According to our latest estimates, DAH hit its peak in 2010 with a historic high in spending of \$28.2 billion. Since 2010, as the shock of the financial crisis began to translate into reductions in development assistance, DAH entered a “no-growth” phase. Figure 5 shows that this period of stagnation has involved a decline in DAH of less than 0.1% in annualized terms and an absolute drop of \$53 million from 2010 to 2012. While DAH has not continued along the strong upward trend observed during the rapid-growth phase, the plateau suggests that international development partners have maintained their commitment to DAH at a fairly stable level.

Shifts within the entire spending envelope underpin the stagnation in DAH. The small aggregate change masks notable decreases and increases across channels. From 2010 to 2012, the most significant change, in absolute and percentage terms, was in spending by GAVI. GAVI spending increased 28.2% in annualized terms, a \$688 million jump from 2010. UN agencies also increased their DAH, contributing \$354 million more in 2012, a 3.9% annual rise. This was in large part driven by UNICEF’s increased expenditure rather than

FIGURE 5:
Change in DAH by channel of assistance, 2010-2012



a uniform increase across agencies. UNICEF played a prominent role in addressing health-related aspects of the response to the natural disasters in Haiti and Pakistan in 2010. Among bilaterals, the UK expanded DAH most notably, with annual growth of 3.4%, an increase of \$80 million, following the UN in absolute and percentage terms. IBRD spending grew 2.3% annually with an absolute change of \$56 million between 2010 and 2012.

Growth in spending by GAVI, as well as by the UN, IBRD, the UK, and a few other bilaterals offset the contraction in other channels, which also occurred across different institution types. GFATM spending shrank 3.4% annually, although, as noted previously, a sharp decrease from 2010 to 2011 was offset by a recovery from 2011 to 2012. IDA's spending also decreased during this period. This arm of the World Bank has seen a shrinking eligibility pool, as fewer countries are considered low income or find it difficult to borrow on world markets. The increase in DAH spending by the UK compensated somewhat for a drop by the US, which shrank 1.2% annually from 2010 to 2012, an absolute decrease of \$164 million. From 2010 to 2012, DAH provided by US foundations and NGOs decreased at rates similar to the bilateral aid agencies: around 5.5% and 3.7%, respectively, on an annual basis. The reduction in EC and other bilateral spending constituted the most significant drop at \$447 million, a 5.6% annualized decrease from 2010.

In sum, these shifts reveal an increasingly prominent role for multilaterals, including the UN, World Bank, and GAVI. The overall contraction was largely driven by decreases in bilateral spending, including the US and EC, as well as reductions in expenditure by NGOs and GFATM. The increase in GAVI spending, coupled with the decreases in GFATM spending, indicates significantly increased spending on vaccines and reductions in expenditure on TB, HIV/AIDS, and malaria programs. With the exception of the UK and a few other bilaterals, bilateral spending is down significantly.

DAH versus ODA trends

The trends in DAH were not always reflective of patterns in wider ODA. Table 1 reports the total ODA and DAH at a baseline of 1990 and at the end of the moderate- and rapid-growth phases. Due to the lag in reporting, total ODA and DAH in the no-growth phase are examined only for 2011. While DAH was rising modestly from 1990 to 2001, ODA, in fact, stagnated. ODA decreased from \$99 billion in 1990 to \$92.2 billion 2001. However, over the course of DAH's rapid-growth phase, ODA also experienced strong growth. In 2010, total ODA had increased to an all-time high of \$148.4 billion, just as DAH reached its historic peak of \$28.2 billion. ODA's rise was not quite as strong as the growth in DAH over that period. As ODA expanded 61% between 2001 and 2010, DAH almost tripled concurrently. Discussing the more recent period of stagnation is difficult, since IHME relies on preliminary estimates for DAH, and ODA figures are not currently available for 2012. However, the no-growth phase appears to be affecting both ODA and DAH. In 2011, year-over-year decreases were observed in both DAH (2.6%) and ODA (1.2%).

Since DAH is not exactly comparable to ODA (DAH includes contributions from NGOs and foundations), we also examined the portion of ODA spent on health relative to total ODA.

Although it does not coincide with the absolute increases in DAH observed, the share of health ODA has also grown over the last two decades. As a portion of total ODA, health ODA grew most rapidly from 1990 to 2000. In 1990, the share of health ODA was less than 2%.¹⁹ By 2000, this share had climbed to almost 8%. Health ODA expanded at a moderate pace while ODA stagnated. From 2000 to 2004, however, health ODA remained stable, as health ODA and total ODA both climbed quickly during this period. Since 2004, the portion of health ODA has fluctuated, dropping first to almost 7% in 2006, followed by a jump to almost 12% by 2007. By 2010, health ODA was more than 12% of total ODA.

TABLE 1:
Select total DAH and ODA, 1990-2011

	Baseline	End of moderate-growth phase	End of rapid-growth phase	Beginning of no-growth phase
Year	1990	2001	2010	2011
DAH	\$5.7 billion	\$10.8 billion	\$28.2 billion	\$27.4 billion
ODA	\$99.0 billion	\$92.2 billion	\$148.4 billion	\$146.6 billion

Source of total ODA: OECD.Stat Extracts, Total Flows by Donor [online database]. Paris: Organisation for Economic Co-operation and Development; 2012 Dec 17. <http://stats.oecd.org/Index.aspx?datasetcode=TABLE1#>