

CHAPTER 5:

GOVERNMENT HEALTH EXPENDITURE

Financing Global Health 2012 focuses primarily on DAH, but this is not meant to eclipse the very prominent role of government health expenditure (GHE) in covering the costs of health care in developing countries. GHE constitutes the vast majority of spending on health. Although DAH also contributes to GHE, we make a special effort to isolate the spending by governments in which the funds are sourced domestically (GHE-S) to understand the contribution governments make from tax revenues and other sources of income. In 2010, while total DAH reached \$28.2 billion, GHE for the same set of countries was more than 18 times higher, at \$521 billion. Our GHE-S estimates underline the vital part governments play in supporting the provision of health services to billions of people across the world.

As discussed in Chapter 4, the lasting impact of the financial crisis on OECD countries may lead to continued stagnation or even future decreases in levels of DAH. As OECD governments begin weighing the trade-offs involved in different spending cutbacks, a number are considering reductions in aid to middle-income countries.²³ This may not happen for some time, as aid is phased out slowly. However, as aid is siphoned more toward low-income countries, increasing the ability of middle-income countries to collect taxes to cover health care and other costs is now on the agenda of development assistance partners.⁵² In coming years, developing countries may rely even more substantially on GHE to finance health services.

Government health expenditure from domestic sources

Figure 31 shows that, in 2010, the bulk of governmental spending on health was in East Asia (\$160 billion) at 30.6% of total GHE in GBD developing regions. This is consistent with the large population in that region and the sheer magnitude of growth observed there over the last 10 years. Tropical Latin America followed in terms of GHE spending in 2010 (\$91.2 billion). North Africa/

Middle East, at \$83.8 billion, had the third highest GHE among GBD developing regions.

In comparison, the total GHE for all of sub-Saharan Africa was \$29.4 billion in 2010. While this sum was small compared to other regions, governmental expenditure on health was nonetheless 3.6 times larger than the combined DAH disbursed in sub-Saharan Africa. The total GHE provided throughout sub-Saharan Africa has increased consistently since 2001. However, these increases must be considered relative to the Abuja Declaration targets: In 2001, African Union governments pledged to provide at least 15% of their annual budgets to health.⁵³ By 2011, 26 African countries had increased government expenditure on health, although only one had reached that target. In another 20 countries, the proportion of government expenditure on health had decreased or remained stagnant.⁵⁴

Much like DAH, GHE growth rates have been consistently high over the last 10 years. As displayed in Figure 31, GHE has grown reliably over the last decade; substantial growth has ensued every year since 1995. The increase from 2009 to 2010, at 6% growth, was somewhat smaller than in previous years, which topped 15.7% from 2008 to 2009 and 10.7% from 2007 to 2008. The region with the highest growth from 2009 to 2010 was East Asia, which bounded up 10.1%. Also experiencing respectable rates of growth were Southeast Asia (7.6%), the Caribbean (7.3%), and Latin America (5.7%). On the whole, GHE in sub-Saharan Africa shrank 3.2%, although this was driven by a decrease in governmental spending in Central sub-Saharan Africa (35.4%).

DAH provided to governments versus non-governmental organizations

Research by IHME and others has identified that the DAH distributed through governments (DAH-G) has a different effect on governmental behavior than the effect of DAH allocated to NGOs (DAH-NG).⁵⁵ For this reason, IHME makes a special effort to parse out DAH-G

FIGURE 31:
GHE-S by Global Burden of Disease developing region, 1995-2010

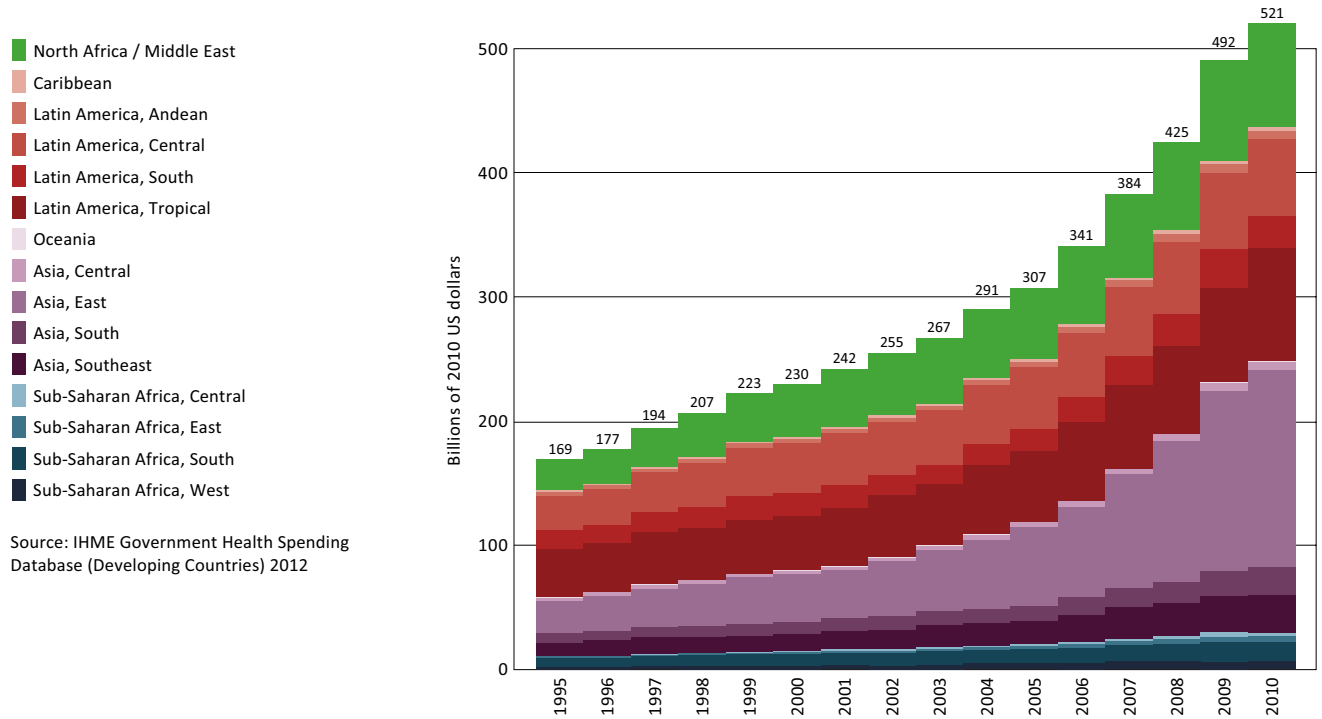


FIGURE 32:
DAH-G by Global Burden of Disease developing region, 1995-2010

The upper-most number in each column is the sum of DAH-G and DAH-NG for that year.

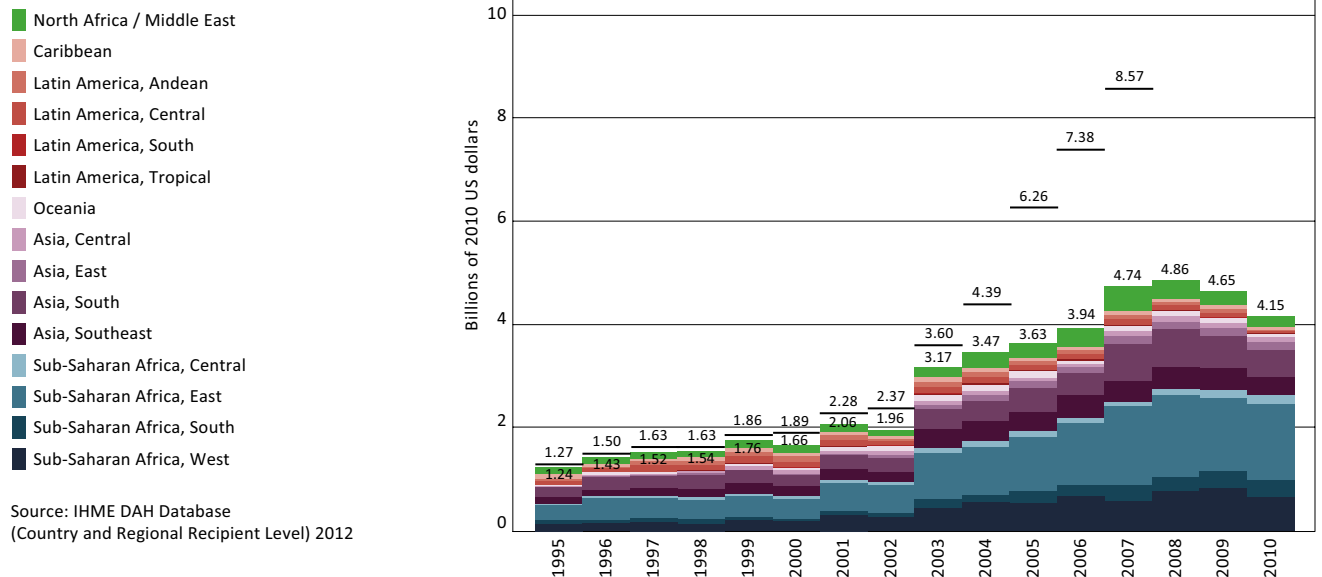


FIGURE 33:
DAH-NG by Global Burden of Disease developing region, 1995-2010

The upper-most number in each column is the sum of DAH-G and DAH-NG for that year.

- North Africa / Middle East
- Caribbean
- Latin America, Andean
- Latin America, Central
- Latin America, South
- Latin America, Tropical
- Oceania
- Asia, Central
- Asia, East
- Asia, South
- Asia, Southeast
- Sub-Saharan Africa, Central
- Sub-Saharan Africa, East
- Sub-Saharan Africa, South
- Sub-Saharan Africa, West

Source: IHME DAH Database (Country and Regional Recipient Level) 2012

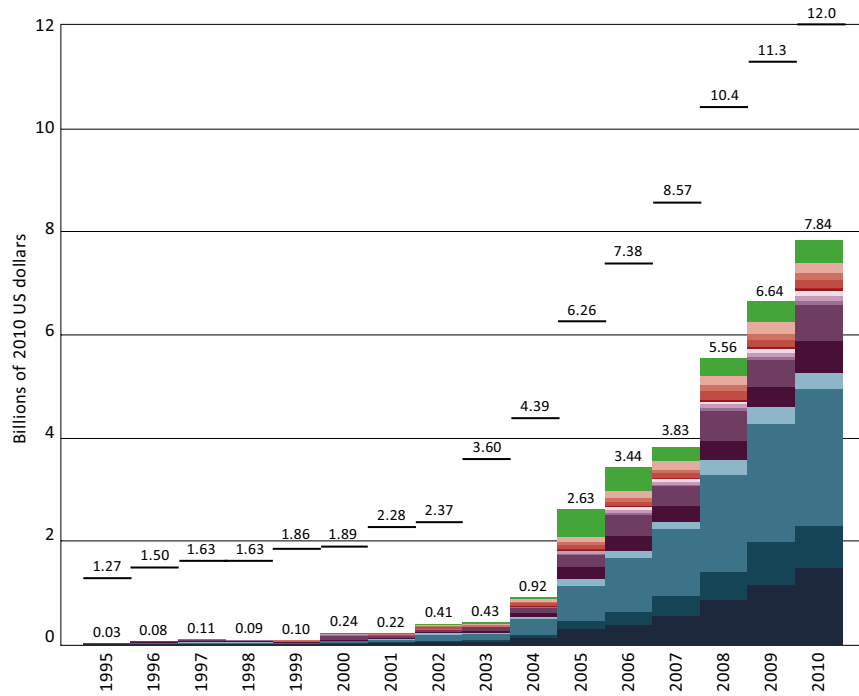
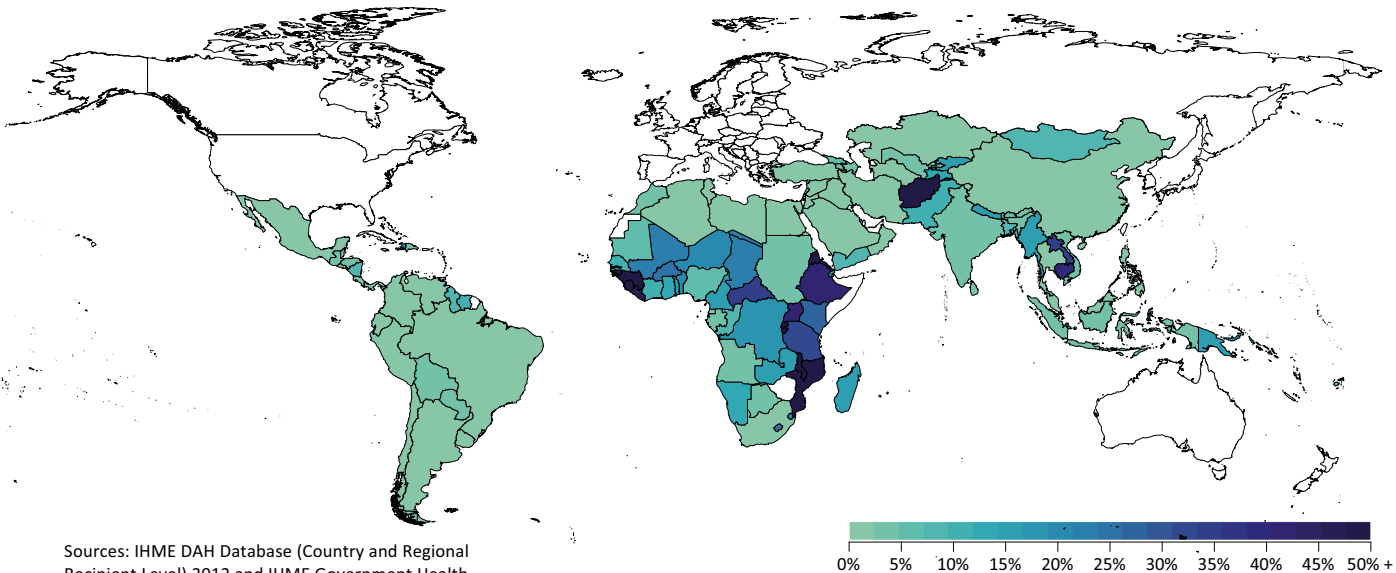


FIGURE 34:
DAH-G as a percentage of GHE, 2008-2010

DAH channeled through developing country governments shown as a percentage of total government health spending. Estimates only shown for Global Burden of Disease developing countries excluding countries for which data were unavailable.



Sources: IHME DAH Database (Country and Regional Recipient Level) 2012 and IHME Government Health Spending Database (Developing Countries) 2012

and DAH-NG. The DAH-G/DAH-NG dataset is produced with different methods and according to different interpretations of development assistance than the DAH data. See the online Methods Annex for further details.

Splitting DAH into these two spending silos reveals how the composition of DAH has changed drastically since 1995. Figure 32 (on page 43) and Figure 33 were created to expose the changes in these two funding streams. Over time, DAH has flowed increasingly to NGOs. Figures 32 and 33 illustrate this trend (the horizontal bars represent the sum of DAH-G and DAH-NG in the corresponding year). In 1995, DAH was mainly distributed to governments; NGOs received approximately \$30 million, 2.4% of total DAH allocable to either DAH-G or DAH-NG. By 2010, DAH-NG made up 65.3% of that total, with more than \$7.8 billion of DAH-NG spent over that year. This mass increase of DAH-NG spending corresponds with the rapid-growth phase of 2001 to 2010, illuminating the key role this type of DAH played in the accelerated rate of growth over the past decade.

DAH-G has made up an increasingly smaller proportion of DAH in recent years; it has also decreased in absolute dollar terms. As Figure 32 illustrates, DAH-G reached a historic high of \$4.86 billion in 2008. Since then, the level of funds dedicated to this form of DAH has slowly declined. At \$4.5 billion, DAH-G shrank 10.8% from 2009 to 2010. DAH-G contracted across regions, with the exception of Central Asia and Central and East sub-Saharan Africa. Sub-Saharan Africa, at 63.2% of total DAH-G in 2010, received the vast majority of DAH-G.

In contrast to DAH-G, DAH-NG increased tremendously from 2001 through 2010. DAH-NG reached \$7.8 billion in 2010. This is \$3.7 billion higher than DAH-G that same year. From 2009 to 2010, DAH-NG increased 18.1% and growth was observed across regions, with the exception of the Caribbean. DAH-NG in Southeast Asia grew significantly (53.1%), as did South Asia (39.9%). Sub-Saharan-Africa, which received the most substantial portion of DAH-NG (67.2%), also grew in 2010 (14.6%).

Finally, the amount provided to governments as DAH must be considered with respect to total government spending on health. In most countries that receive DAH, this development assistance makes up only a small amount of total spending by governments on health. Figure 34 puts that relationship in perspective

by comparing DAH-G to GHE. Most countries received less than 10% of governmental funds spent on health as DAH. This was true across most of South America, North Africa, and Asia. Even in India, the country that received the most absolute DAH, the government still supplied the vast majority of public health financing.

However, certain countries in sub-Saharan Africa and Asia receive a much higher proportion of DAH-G relative to total government expenditure on health, as Figure 34 highlights. In West and South sub-Saharan Africa as well as in a few countries in Asia, DAH makes up a major proportion of government health expenditure. The reliance of these health systems on DAH, as measured by DAH's share of government health spending, should be considered in light of the decreasing levels of DAH-G from 2008 to 2010, as shown in Figure 32. Given the reliance on outside sources of funding, these governments should be aware of the vulnerability of their health systems to drops in DAH.