

CONCLUSION

There is rising concern in the global health community that the dramatic growth in development assistance for health (DAH) since 1990 is likely to stagnate in the years ahead. With the evidence that we have been able to gather to date, we have found that trends in global health financing may not be as dire as some fear.

Much of the anxiety stems from recent reports about financial commitments to large global health efforts. In September 2010, the UN Millennium Development Goal Gap Task Force released a report predicting that total development assistance from donor governments for all sectors would rise from \$120 billion in 2009 to \$126 billion in 2010 but would fall short of the promises made by the Group of Eight nations at a 2005 summit at Gleneagles in Scotland.⁷⁵ In October 2010, donors pledged \$11.7 billion in new commitments to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), which was short of GFATM's goal. To keep programs funded at their current levels, GFATM was hoping to receive new commitments of at least \$13 billion.⁷⁶

Despite some disappointment among aid experts, the pledged amount to GFATM is notable for three reasons. It marked a new high for three-year GFATM commitments.⁷⁷ The United States offered \$4 billion over three years, an increase of nearly 40% over its last pledge.⁷⁸ And the next largest commitment was a \$300 million pledge from the Bill & Melinda Gates Foundation, a sign of continued strength in the private donor sector.⁷⁷ *Foreign Policy* wrote: "That number dwarfs almost all country donors – including countries known for giving a relatively high proportion of their GDPs to aid: Norway, Denmark, and Australia. What a new world it is where the richest foundation in the United States can outspend the world's most generous national donors."⁷⁹

While the evidence shows that DAH continues to grow, though at a slower pace, our analysis also raises questions about whether DAH is always aligned with need, as seen in the relationship between DAH and disability-adjusted life years. Some countries with relatively low

disease burdens continue to receive disproportionately high amounts of DAH, while some countries with greater disease burdens receive less. Criticism of how health focus areas are funded will likely increase as the aid pool shrinks and competition for DAH intensifies. When the United Nations General Assembly meets in September 2011 to discuss noncommunicable diseases, the group will be faced with balancing the funding needs of the pressing health problems presented by infectious diseases with the growing burden of heart disease, cancer, diabetes, and other chronic diseases.¹⁰

In the midst of the economic crisis, innovations in health interventions continue to emerge, providing both simple and technologically advanced solutions to seemingly intractable health problems. In *PLoS Medicine* in August 2010, the Institute for Health Metrics and Evaluation (IHME) and its collaborators published a paper that showed how the distribution of relatively low-cost insecticide-treated bed nets has expanded rapidly throughout Africa.⁷¹ Major pharmaceutical companies have invested in new drugs and treatments that are starting to be sold in developing countries to combat a variety of diseases. These will address unmet needs, and they also will require new funding. The most important funders, as we have shown, will be the governments themselves, regardless of the amount of DAH they receive.

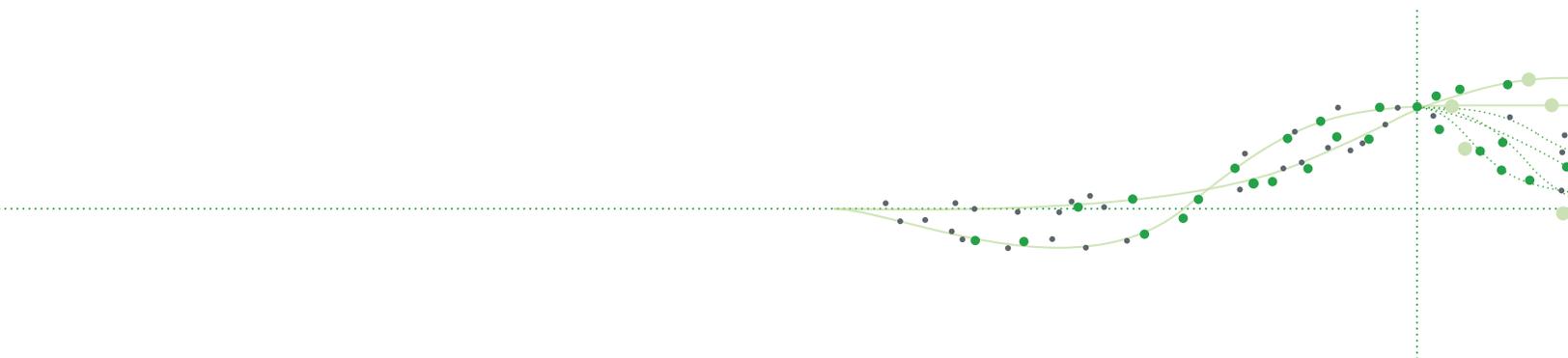
In this regard, the news in recent years has been good. The developing world's commitment to health grew dramatically over the past two decades. Still, a significant portion of the countries with the greatest need for robust health spending also decreased their commitments to health as they have received more DAH. If countries fall behind now in health spending, it will be even harder for them to catch up. Reports by IHME,⁸⁰ the United Nations Development Programme,⁸¹ and other organizations have shown that a minority of countries are on track to reach the Millennium Development Goals for reducing child and maternal mortality by 2015. Given these concerns, we must recognize the importance of country spending on health and look for ways to maximize its impact.

One area for improvement we have identified is funding transparency. In an era where so much information is available online, it is surprising that civil society groups and citizens in countries cannot easily find out what their governments spend on different sectors, including health. Tremendous progress has been made on making donor funding more transparent in the past few years. Leadership by the World Bank, the International Monetary Fund, the World Health Organization, and country governments is needed to bring that same level of transparency to spending by finance ministries.

In tandem with greater transparency, more discussion is needed on how to build the capacity of recipient governments to make better use of DAH. There is anecdotal evidence that because ministries of health are only equipped to handle a certain level of funding, ministries of finance do not increase health funding

in light of increased DAH.⁸² Very little is known about this area, and one approach would be to identify cases where implementation capacity has been a factor when governments either increased their spending on health after receiving DAH or reallocated country spending to other sectors. Case studies could provide important evidence for both donor and recipient countries regarding key factors that contribute to declining shares of government spending on health.

The next step would be to study the impact of DAH on health to see whether donors and recipients are getting value for the health money invested. More spending does not necessarily improve population health. It is only through careful evaluation of spending as it relates to health determinants and health outcomes over time that we will find the right tools to build a path to better health for all countries and their populations.



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