CONCLUSION

A new era in development assistance for health (DAH) is emerging. After a decade and a half of sustained growth, DAH dropped in 2011 for the first time since 1990. Preliminary estimates by the Institute for Health Metrics and Evaluation (IHME) reveal that DAH has been marked by stagnation since 2010. This plateau raises a number of considerations as the global health community enters a new age of DAH.

The stagnation has thus far not been uniform across institutions. Our preliminary estimates show that while bilaterals dropped, multilaterals continued to grow. Among public-private partnerships, GAVI Alliance financing sustained its impressive trajectory, while that of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) decreased slightly from 2010 to 2012. Non-governmental organizations sustained their share.

The DAH flatline follows a decade of impressive growth rates. From 2001 to 2010, DAH grew tremendously, with increases across funding streams for the myriad of organizations that provide DAH. Public-private partnerships, foundations, and non-governmental organizations benefited most substantially as their role in DAH evolved. Spending by bilaterals also increased significantly, while multilaterals maintained consistent growth throughout the period.

The golden age of consistently higher growth in DAH relative to official development assistance (ODA) may have also ended. Previously, DAH growth significantly outpaced increases in broader ODA. Over the course of the moderate-growth period (1990 to 2001) and rapid-growth period (2001 to 2010), the portion of ODA dedicated to health increased substantially. As the no-growth phase emerges, there is evidence that a new trend is materializing: The drop in DAH from 2010 to 2011 coincides with a comparable decrease in ODA.

These changes come as the global health community embarks on a new funding cycle. Donors will consider the replenishment of funds of the International Development Association (IDA), GFATM, and other organizations in 2013. The fiscal adjustments of Organisation for Economic Co-operation and Development countries, the graduation of many countries to middle-income status, and the impending 2015 Millennium Development Goals (MDGs) deadline will all play into these fundraising efforts. IDA-eligible countries have dwindled to one-third of the original pool, which are almost exclusively located in sub-Saharan Africa (80%). Creating a transitional "IDA+" window has been posed as a suggestion to smooth countries' transitions out of IDA eligibility. Expanding IDA objectives is being explored as well.[56] Also, GFATM will be convening donors to replenish funds in 2013. In recent years, GFATM has tightened its eligibility criteria for upper-middle-income countries and, in late 2012, announced it will be introducing a new funding model as well.

If the stagnation continues, other sources of financing may become increasingly important to meeting global health needs, including progress toward the MDGs. We are still far from achieving these targets in many countries, and DAH has buoyed progress toward these objectives. However, traditional aid partners are reconsidering their development assistance policies as they weigh budgetary cutbacks. Furthermore, as countries graduate to middle-income status, questions are being raised about the continued role of ODA. It has been suggested that government health expenditure, private-sector funding, and innovative financing mechanisms, such as public-private partnerships, may increasingly address health needs in middle-income as well as low-income countries in years to come.[57] Boosting the capacity of middle- and low-income countries to mobilize domestic resources has also been on the agenda of late.[49-51]

As development assistance partners make decisions about new funding commitments, the shifts in DAH, as exposed in *Financing Global Health 2012,* should be kept in mind. Fluctuations in funds and the consequent implications for the institutional and health focus mix will impact the international community's ability to face global health challenges. If DAH for certain health focus areas, such as malaria, noncommunicable diseases, and health system support, continues to wane, decision-makers need to be cognizant of the impact. If bilateral spending continues to drop, the increasing prominence of other actors must be taken into consideration. Furthermore, attention will also have to be paid to income-based allocation of funds. Any retreat from DAH for middle-income countries should be observed closely, as three-quarters of the world's poor now reside in middle-income countries.[58]

Accurate and timely information is thus increasingly necessary if decision-makers are to respond to a quickly evolving global health landscape. Fortunately, this type of information is more likely to be at the fingertips of policymakers due to efforts like *Financing Global Health*. In years to come, this publication and others can ensure stakeholders are able to make informed decisions about a multitude of global health challenges.

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