The Global Financial Crisis Has Led To A Slowdown In Growth Of Funding To Improve Health In Many Developing Countries

ABSTRACT How has funding to developing countries for health improvement changed in the wake of the global financial crisis? The question is vital for policy making, planning, and advocacy purposes in donor and recipient countries alike. We measured the total amount of financial and in-kind assistance that flowed from both public and private channels to improve health in developing countries during the period 1990–2011. The data for the years 1990–2009 reflect disbursements, while the numbers for 2010 and 2011 are preliminary estimates. Development assistance for health continued to grow in 2011, but the rate of growth was low. We estimate that assistance for health grew by 4 percent each year from 2009 to 2011, reaching a total of $27.73 billion. This growth was largely driven by the World Bank’s International Bank for Reconstruction and Development and appeared to be a deliberate strategy in response to the global economic crisis. Assistance for health from bilateral agencies grew by only 4 percent, or $444.08 million, largely because the United States slowed its development assistance for health. Health funding through UN agencies stagnated, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria announced that it would make no new grants for the next two years because of declines in funding. Given the international community’s focus on meeting the Millennium Development Goals by 2015 and persistent economic hardship in donor countries, continued measurement of development assistance for health is essential for policy making.

Development assistance for health increased rapidly over the past decade, but its annualized rate of growth slowed following the global financial crisis. Some economists have predicted that foreign assistance to developing countries will decline in the wake of the recession. In fact, in November 2011 the Global Fund to Fight AIDS, Tuberculosis, and Malaria (commonly known as the Global Fund) announced that it would make no new grants until 2014, in large part because of depressed donations attributed to the global financial crisis. However, some researchers have found that assistance for health may be more resilient than other types of aid, because aid for health did not decrease during previous downturns. In Financing Global Health 2010: Development Assistance and Country Spending in Economic Uncertainty, we noted that it was unsurprising that funding for health in developing countries con-
continued to rise, because it was driven largely by financial contributions from governments that were committed before the recession began and were spread over multiple years. Nevertheless, ongoing economic distress creates uncertainty regarding future levels of development assistance for health.\textsuperscript{5–10} Our findings quantify the reduced growth of development assistance for health in the wake of the global recession and track its slower but continued rise through 2011.

We measured the total amount of financial and in-kind assistance that flowed from development organizations, or channels of assistance, to improve health in developing countries during the period 1990–2011. We tracked assistance for health from both public and private channels such as bilateral organizations of member countries of the Organization for Economic Cooperation and Development’s Development Assistance Committee; nongovernmental organizations and foundations based in the United States; public-private partnerships such as the Global Fund and the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization); and institutions such as the World Bank and other regional development banks.

A major challenge in tracking development assistance for health comes from the long time lag between disbursements of funds and publication of data about these disbursements. We overcame this challenge by using budget documents, financial statements, and correspondence with donors to produce preliminary estimates of development assistance for health for the years lacking published disbursement data. Despite an inevitable margin of error in our prediction, the validity and utility of these estimates is supported by the fact that our preliminary estimate of total development assistance for health in 2009 was within 1 percent of the estimate generated this year from actual disbursement data.\textsuperscript{1}

\textbf{Study Data And Methods}

We estimated development assistance for health for the years 1990–2011. All estimates are presented in constant 2009 US dollars. The data for the years 1990–2009 reflect disbursements, while the numbers for 2010 and 2011 are preliminary estimates.

We defined \textit{development assistance for health} as financial and in-kind contributions made by channels of development assistance—that is, by institutions whose primary purpose is providing development assistance to improve health in developing countries. The estimates included \textit{general health-sector support}, which is defined as funds that can be used for any area of the health sector, as well as all disease-specific contributions. The definition excluded support for related sectors such as primary education, water and sanitation, and food security.

A key difference between our definition of development assistance for health and global health financing tracked in other studies is that we included loans from the International Bank for Reconstruction and Development, a lending arm of the World Bank, and assistance from private entities such as nongovernment organizations.\textsuperscript{6,11} A forthcoming article by Karen Grépin and colleagues contrasts the different types of health assistance tracked in \textit{Financing Global Health 2010} to those tracked in other global health financing databases.\textsuperscript{1,12}

To generate estimates from the years 1990–2009, we tracked, where possible, all development assistance for health reported by public and private channels of aid. We reviewed both the revenue and disbursement data for each of these channels. The data came from annual reports, government documents, audited financial statements, tax forms, and data sets provided by public and private donors.

To ensure that we did not double-count the same assistance dollars flowing through multiple channels, we subtracted transfers between channels tracked by our study. This process enabled us to segment total assistance by source, channel, and type of funding.

Few channels of assistance that we tracked provided disbursement data for 2010 and 2011. To generate preliminary estimates for those years, we collected the most current data available from sources such as budget documents and financial statements, and we estimated the relationship between budgeted amounts or revenue raised and future expenditures. In some cases we obtained data on 2010 disbursements and estimated 2011 disbursements from correspondence with channels of assistance. The core methods used to generate our results are described in \textit{Financing Global Health 2010}.\textsuperscript{1}

These preliminary estimates might be overestimates if donors have failed to honor their commitments, as indicated by the Global Fund’s recent announcement of its plans to discontinue new grant funding for the next two years as a result of ongoing economic troubles in donor countries.\textsuperscript{5} The uncertainty surrounding our preliminary estimates of development assistance for health in 2010 and 2011 could be avoided if all channels had provided timely disbursement data.

Several new data sources were incorporated into this year’s analysis. Among them, we included health spending from some of the largest nongovernmental organizations in the United States; public-private partnerships such as the Global Alliance for Vaccines and Immunization; and institutions such as the World Bank and other regional development banks.

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States for the years 1999–2010, which allowed us to improve our estimates of development assistance for health flowing through these channels. Also, to strengthen our preliminary estimates, we incorporated into our data set budget data on foreign assistance from South Korea and the Netherlands, along with revised 2010 spending data from sources such as the GAVI Alliance and the Bill & Melinda Gates Foundation. As a result of these new data, our estimates of assistance from these particular sources are notably different from those in our 2010 report.1

Our approach did not account for private donations from countries outside of the United States. This is because of the lack of standardized data on private non-US donations. A study of overall philanthropic contributions from countries on the Organization for Economic Cooperation and Development’s Development Assistance Committee, excluding the United States, indicated that these funds were 60 percent lower than private development assistance for health from the United States in 2008.13

**Study Results**

We estimate that development assistance for health grew by 4 percent each year from 2009 to 2011, reaching a total of $27.73 billion over the two years. This compares to a growth rate of 17 percent between 2007 and 2008. Thus, although development assistance for health continued to grow, it did so slowly. Exhibit 1 reports development assistance for health from 1990 to 2011 by channel of assistance. The new growth rates observed since 2009 are comparable to those observed during the 1990s.

Exhibit 2 summarizes the changes in development assistance for health by channel of assistance from 2010 to 2011. For example, the percentage change from bilateral channels was relatively small, but its contribution to development assistance for health was the second largest in absolute terms.

The responses from funders to the economic crisis have been varied. The World Bank’s International Bank for Reconstruction and Development has contributed substantially to the continued growth of development assistance for health. Assistance from the bank hovered around $1 billion annually from 1997 to 2004 but steadily declined. However, the growth rate in the bank’s assistance began to rise in 2009, increasing by 9 percent from 2008 to 2009 and 28 percent from 2009 to 2010. From 2010 to 2011, development assistance for health from the bank rose by 128 percent, reaching 1.42 billion in 2011. The change in financing from this

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**Exhibit 1**

Development Assistance For Health, By Channel Of Assistance, 1990–2011

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**Source** Institute for Health Metrics and Evaluation development assistance for health database 2011. **Notes** Estimates are in billions of 2009 US dollars. Data for 2010 and 2011 are preliminary estimates based on information from the above organizations, including budgets, appropriations, and correspondence. NGO is nongovernmental organization. BMGF is Bill & Melinda Gates Foundation. GFATM is Global Fund to Fight Aids, Tuberculosis, and Malaria. GAVI is GAVI Alliance. WHO is World Health Organization. UNICEF is United Nations Children’s Fund. UNFPA is United Nations Population Fund. UNAIDS is Joint United Nations Programme on HIV/AIDS. PAHO is Pan-American Health Organization. IBRD is International Bank for Reconstruction and Development. IDA is International Development Association. SWE is Sweden. DEU is Germany. FRA is France. JPN is Japan. UK is the United Kingdom. US is the United States.
institution from 2010 to 2011 accounted for $797 million of the growth in total development assistance for health in that year. This scale-up in financing appears to be part of the World Bank’s response to the global economic crisis to help developing countries stimulate their economies and provide social safety nets for their citizens.14,15

The scaling up by the International Bank for Reconstruction and Development marks a shift in the landscape of development assistance for health because this funding is primarily targeted toward middle-income countries instead of low-income countries.16 The bank provides aid for health in the form of loans, whereas many other channels of assistance offer grants that do not have to be repaid.16

There is some debate about whether the bank’s loans should be counted as development assistance for health. Although some researchers exclude the loans,17 we chose to include them, to maintain consistency with previous studies of health assistance for developing countries.12 If these loans had been excluded from our estimates, then total development assistance for health would have increased only 1 percent between 2010 and 2011 instead of 4 percent (an increase of $269.75 million instead of $1.07 billion).

At the same time that the World Bank has increased development assistance for health through its International Bank for Reconstruction and Development, an opposite trend has prevailed in its fund for poor countries, the International Development Association. This fund primarily provides interest-free credits and grants to the poorest countries.17 Development assistance for health from the fund has decreased since 2006. However, it recently experienced substantial fund-raising success at its sixteenth replenishment in 2010.18 Therefore, it will be important to examine the replenishment’s impact on the fund’s assistance in the future.

Development assistance for health channeled through bilateral agencies was the main driver of growth in health funding for developing countries from 2002 until 2010, with a 14 percent annualized increase. Funding from bilateral agencies increased by 12 percent between 2009 and 2010, yet from 2010 to 2011 assistance for health from bilateral agencies grew by only 4 percent, or $444.08 million. This slowdown is largely because the United States slowed its de-
development assistance for health. However, bilateral channels were still the second-largest contributors to the total growth of funding assistance for health from 2010 to 2011.

The annualized growth rate of development assistance for health channeled through UN agencies slowed after the recession, from 6 percent between 2005 and 2008 to only 2 percent between 2008 and 2011. Development assistance for health from UN agencies increased by 4 percent from 2009 to 2010 but decreased by 1 percent from 2010 to 2011. The only one of these agencies that did not experience a decline in assistance from 2010 to 2011 was the Pan-American Health Organization.

The real value of services provided by UN agencies might be overstated when measured in US dollars. For example, the World Health Organization receives its revenue in US dollars but pays its headquarters staff in Swiss francs. One US dollar was worth 1.20 Swiss francs in 2007 but only 0.92 Swiss francs in 2011. Therefore, the number of staff hours the organization can purchase with a given amount of revenue has declined substantially over this time. This is noteworthy because staff salaries are a large part of the World Health Organization’s budget.

Slower growth rates of development assistance for health channeled through UN agencies are not a new phenomenon. The agencies’ share of total development assistance for health decreased from 21 percent in 2002 to 14 percent in 2011, principally because other channels grew faster.

As UN agencies’ dominance has declined, newer actors such as the GAVI Alliance and the Global Fund have emerged and channeled increasingly larger shares of development assistance for health to developing countries. The GAVI Alliance’s share of total development assistance for health grew from 1 percent in 2002 to 4 percent in 2011. Our preliminary estimates indicate that the GAVI Alliance’s growth rate was 5 percent from 2009 to 2010. Its rate of growth rose to 31 percent between 2010 and 2011, to reach a total of $1.7 billion.

The Global Fund’s share grew from 2 percent of total development assistance for health in 2003, the second year of its existence, to 10 percent in 2011. Since the Global Fund’s establishment, it has experienced remarkable year-over-year growth, from $16.28 million in 2002 to $2.91 billion in 2009. Development assistance for health from the Global Fund grew 11 percent from 2009 to 2010. However, our preliminary estimates indicate that health assistance channeled through the Global Fund declined $529 million, or 16 percent, between 2010 and 2011. Before the recession, donors’ disbursements to the Global Fund were approximately the same as their commitments. However, donors disbursed 94 percent of commitments in 2009 and only 78 percent of commitments in 2010. The Global Fund’s recent announcement about its plans to scale back funding because of reduced revenue indicates that certain donors continued to disburse less than they had committed in 2011.

Discussion And Policy Implications
Our estimates reveal four trends that have important implications for global health financing.

First, multilateral development assistance for health continued to grow through 2011, but there have been shifts in both the recipients and the purpose of this assistance. The changes stem in part from the expanded role of the International Bank for Reconstruction and Development because this channel provides loans primarily to middle-income countries for the purpose of health improvement and broader economic stimulus. In contrast, development assistance for health from the fund of the World Bank for the poorest countries, the International Development Association—which provides grants and interest-free, long-term credits to low-income countries—has decreased.

Second, there has been a shift in bilateral development assistance for health. Between 2002 and 2010, this was the main source of the massive increases in assistance for health. But in 2011, growth from this channel slowed to its lowest annualized rate since 2001. Consequently, the prospect of renewed expansion of development assistance for health at recently observed growth rates seems unlikely. Also, much of the slowdown in bilateral assistance for health stems from the slowdown of assistance from the United States. The slowdown may indicate that recipients of the largest US health assistance funds, such as countries in the President’s Emergency Plan for AIDS Relief partnership framework, will feel the effects of the slowdown most acutely.

Third, stagnation in UN funding may pose risks to several health focus areas in which these channels play an important role. UN agencies collectively represent a large fraction of funding to several priority health areas. The three areas most dependent on UN support are maternal and child health (the United Nations provided 37 percent of total development assistance for health for this area in 2009), noncommunicable diseases (25 percent), and tuberculosis (16 percent). It is unclear how well other channels are positioned to reallocate their funding to these areas, which may be problematic for the achieve-
ment of Millennium Development Goals if UN development assistance for health continues its current trend.

Fourth, newer actors such as the GAVI Alliance and the Global Fund have channeled large shares of total development assistance for health over the past decade. The GAVI Alliance is still experiencing rapid growth, but the Global Fund’s growth appears to have stalled.

The GAVI Alliance’s success in securing a steady stream of financing despite economic hardship in donor countries could partly be a result of the long-term funding provided by the International Finance Facility for Immunisation.21 Meanwhile, the Global Fund’s share of total development assistance for health increased quickly between its establishment in 2002 and 2010, but a recent report from its High-Level Independent Review Panel suggests an institutional shift in focus from prioritizing the speed and size of disbursements to ensuring the effectiveness of and accountability for grants.22 Given the panel’s recommendations and the Global Fund’s announcement that cuts in donor funding have made it necessary to stop providing new grants,2 development assistance for health from the Global Fund might not expand as rapidly as it has in the past.

As economic hardship persists in many donor countries, growth in development assistance for health has slowed but continues to rise overall. Because assistance for health is considered to be critical for meeting the Millennium Development Goal targets,23 continued measurement of its levels in the current economic climate is important for policy making, planning, and advocacy efforts in donor and recipient countries alike. ■

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NOTES


4 Tordjman J. Recession weighs heavily on aid to poor countries [Internet]. Paris: AFP; 2009 May 23 [cited 2011 Oct 13]. Available from: http://www.google.com/hostednews/apf/article/ALeqM5hVYi6xrmlx0V3D2UEtd2wAo9LoQ


In this month’s Health Affairs, Katherine Leach-Kemon and coauthors report on their measure of the total amount financial and in-kind assistance that flowed from both public and private sources to improve health in developing countries in the years 1990 to 2011. Their goal was to assess the impact of the global financial crisis on funding for health improvement in these countries. The authors discovered that development assistance for health continued to grow after the economic downturn began in 2008, but the rate of growth slowed to 4 percent from 2009 to 2011.

Most of the authors are affiliated with the Institute for Health Metrics and Evaluation (IHME) at the University of Washington. The institute is an independent global health research center focused on the challenges of measurement and evaluation in the areas of health outcomes; health services; financial and human resources; evaluations of policies, programs, and systems; and decision analytics. It was launched in 2007 with the goal of providing an unbiased, evidence-based picture of global health trends and determinants to inform the work of a broad range of organizations, policy makers, researchers, and funders.

Leach-Kemon is data development manager at the institute, where she researches development assistance for health and government health expenditure in developing countries. She also works to build awareness of the institute’s research internationally and assists fellow researchers in their data-gathering efforts. She holds a master of public health degree in global health from the University of Washington.

David Chou is a postbachelor fellow at the Institute for Health Metrics and Evaluation. His work centers on global health financing, specifically tracking development assistance for health and government health expenditure and measuring the burden of gastrointestinal diseases and injuries on health. He received his bachelor’s degree in public policy from Duke University.
Matthew Schneider, a postbachelor fellow at the University of Washington during the study, is a research consultant at the Center for Global Development, in Washington, D.C. His interests range from malaria and maternal and child health to health financing, health economics, and international development. He holds a master of public health degree with a focus in global health metrics and evaluation from the University of Washington.

Annette Tardif is a data analyst at the Institute for Health Metrics and Evaluation. She has a bachelor’s degree from Colorado College and is pursuing a master’s degree in psychology from Seattle University.

Benjamin Brooks is a postbachelor fellow and member of the health financing research team at the institute. He holds a bachelor of science degree from the biomedical engineering program at the University of Virginia.

Michael Hanlon is a lecturer at the Institute for Health Metrics and Evaluation. He is one of Amazon.com’s first employees, working as a software developer among a variety of roles from 1995 to 2001; he uses his experience developing software in a series of projects that incorporate machine-learning techniques. He earned his doctorate in economics from the University of Washington.

Joseph Dieleman is a research assistant with the institute and a doctoral student in economics at the University of Washington. His research revolves around understanding the determinants of health and the relationship between development assistance for health, government health expenditure, and health outcomes.

Michael Murray is director of the Institute for Health Metrics and Evaluation and a professor of global health at the University of Washington. A physician and health economist, he has worked on projects that have led to the development of a range of new methods and empirical studies to strengthen the basis for population health measurement, measure the performance of public health and medical care systems, and assess the cost-effectiveness of health technologies.

From 2003 until 2007 Murray was the director of the Harvard University Initiative for Global Health and the Harvard Center for Population and Development Studies, as well as the Richard Saltonstall Professor of Public Policy at the Harvard School of Public Health. He earned his doctorate in international health economics from Oxford University and his medical degree from Harvard Medical School.