

The urgent case for expanded development assistance for health

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The low-income developing countries require increased development assistance for health (DAH) to achieve Sustainable Development Goal 3, 'Healthy Lives for All'. DAH has a proven track record. DAH expanded during 2001–2008, with significant health gains in the LIDCs, but then stopped expanding in the wake of the 2008 financial crisis. The Global Fund to Fight AIDS, TB and Malaria requires around US\$31.8 billion during 2021–2023 to maintain a trajectory to end the three epidemics by 2030, yet donors have so far signaled that they are prepared to offer less than half that sum, around US\$14 billion.

Keywords: AIDS, development assistance, malaria, sustainable development goals, TB, universal health coverage

Twenty years ago I was honored to chair the Commission on Macroeconomics and Health for WHO. Our 2001 report, *Investing in Health for Economic Development*,¹ reached three main conclusions. First, the economic returns to investing in health were indeed enormous. Second, that poor countries did not have the fiscal resources, by themselves, to undertake the necessary investments. Third, increased development assistance for health (DAH) that was well targeted and supported by health professionals would provide an enormous boost to public health in low-income countries at very modest costs.

That report, in conjunction with the launch of the Millennium Development Goals for 2000–2015, gave an impetus to DAH. The Global Fund to Fight AIDS, TB and Malaria was launched by the then-United Nations (UN) Secretary-General Kofi Annan in 2001, and became operational in 2002.² The Global Alliance for Vaccines and Immunizations (GAVI), launched in 2000, initiated a bold program of vaccine scale-up to the world's most vulnerable children.³ The USA launched its President's Emergency Plan for AIDS Relief (PEPFAR) program in 2003 to fund the fight against AIDS alongside the new Global Fund. In 2005, the USA launched the President's Malaria Initiative (PMI), again expanding the resources available for malaria control. In 2008, the then-UN Secretary-General Ban Ki-moon called for the mass free distribution of antimalaria insecticide-impregnated bednets, which resulted in a massive increase of bednet distribution in the following years. Major initiatives were expanded for other diseases as well, including the fight against polio, as well as against several neglected tropical diseases through support from the United States Agency for International Development (USAID) and the UK Department for International Development to enable the mass distribution of donated drugs from the pharmaceutical sector.⁴

Figure 1 shows the time path of DAH. DAH rose modestly in the 1990s, increasing from roughly US\$8 billion per year in the early 1990s to around US\$14 billion in 2002. After 2002, DAH surged until 2011, reaching around US\$40 billion per year. In the wake of the 2008 financial crisis and the budget stringency that followed, DAH leveled off by 2011, with DAH in 2018 at roughly the same level as in 2011.

The rapid scale-up of official development assistance for health during the first 10 years of the twenty-first century set the stage for major impacts against many infectious diseases, and to an overall acceleration after 2000 in the decline of child and maternal mortality rates.^{5,6} The scale-up experience also established a key result, that more DAH does indeed lead to more disease control and reduced morbidity and mortality. DAH works, with both public health and socioeconomic benefits contributing to poverty alleviation.

Campaigners for health financing recall the words of President George W. Bush at the start of the DAH scale-up. He declared that if the health scale-up works, more money would be made available. Bush promised that money would not be the limiting factor in disease control. Yet history was to prove otherwise.

The plateauing of DAH occurred under President Barack Obama. Obama entered office in January 2009 in the midst of a global financial crisis, one that pushed the US budget deficit to more than US\$1 trillion in financial year 2009. In that context, Obama essentially froze US official DAH. The upward trend of Global Fund financing was ended. Indeed, the Global Fund was thrown into a financing crisis by the donor squeeze led by the USA and joined by other donor countries. During 2011–2013, the Global Fund skipped its normal funding 'round,' postponing new commitments to recipient countries. When the Global Fund

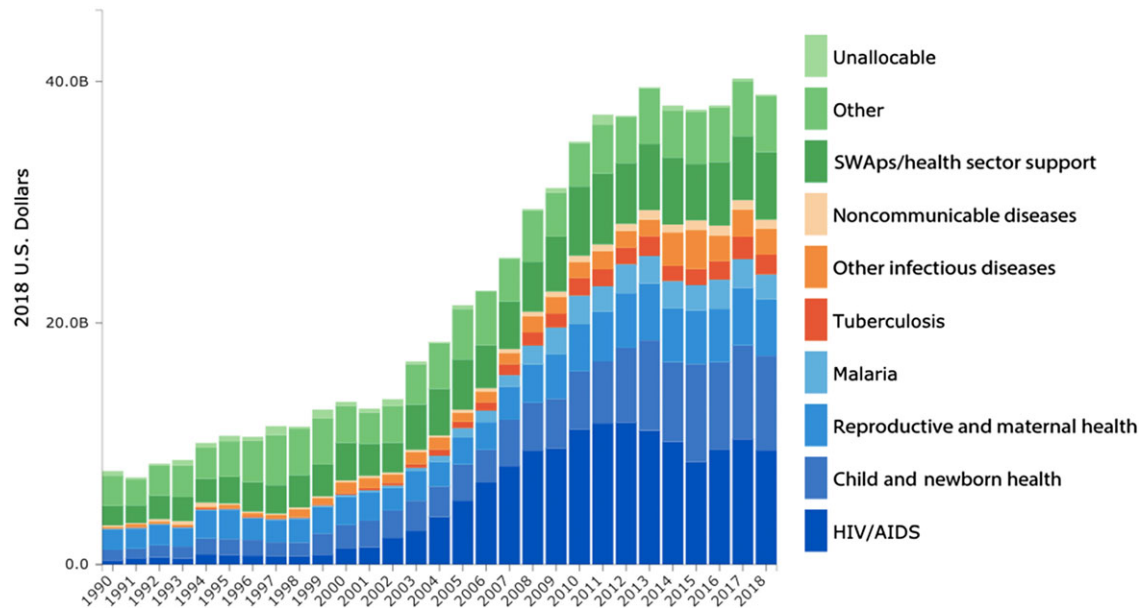


Figure 1. Development assistance for health, 1990–2018 (US\$ billion). Source: Institute for Health Metrics and Evaluation, Financing Global Health Data Base (<https://vizhub.healthdata.org/fgh/>).

emerged from the freeze, it had put new country limits on financing.

With the leveling off of funding came a slowdown of the improvements in health outcomes in the low-income countries. The scale-up of disease control efforts slowed or stopped, although the programs were not totally curtailed. Health progress slowed, and the ambitions of vertical programs such as AIDS control were systematically stymied by a chronic insufficiency of funds.

The Sustainable Development Goals (SDGs), adopted in September 2015, should have given a new boost to disease control in low-income countries. The SDGs call for ambitious targets to cut infant mortality rates, under 5 mortality rates and maternal mortality rates by 2030.^{5,6} They also call for bold efforts to ‘end the epidemics of AIDS, tuberculosis, malaria and neglected tropical disease and combat hepatitis, water-borne diseases and other communicable diseases’ (SDG 3.3). They call for stepped-up efforts against non-communicable diseases (SDG 3.4), the prevention and treatment of substance abuse (SDG 3.5), universal access to sexual and reproductive health services (SDG 3.7) and, perhaps most importantly of all, to achieve universal health coverage (SDG 3.8). Yet oddly and distressingly, to this day in 2019, 4 y on, there has been no increase in official development assistance for health, or indeed for any other area of sustainable development (education, infrastructure, conservation or climate) as a result of the SDGs.

More DAH is urgently needed. Low-income countries cannot achieve SDG 3 without a significant rise of DAH. The reason is easy to demonstrate. Consider a low-income country with gross domestic product per capita of around US\$800 (such as Ethiopia, Haiti or Chad). Countries below US\$1000 per capita typically collect around 20% of gross domestic product in government revenues. For a country at US\$800 per capita, that comes to a meager US\$160 per person. Even if 20% of the

budget is allocated to health (a very high share), that would only be US\$32 per person per year for health coverage, far below the US\$100 or more that is actually needed.

The simple fact is that the poorest countries cannot meet the SDGs unless development assistance is significantly increased. The International Monetary Fund has recently determined that 59 low-income development countries (LIDCs) face a financing gap (measured for the year 2030) of some US\$358 billion to cover their SDG-related investments in three areas: health, education and basic infrastructure (water, sanitation and roads). As of 2020, the financing gap for health would be perhaps US\$50 billion per year. From a global point of view this is not a significant amount, as it is a mere 0.1% of the gross domestic product of the high-income donor countries, but it is far beyond the means of the poorest countries.

The current dire situation of underinvestment in health in the low-income countries is well illustrated by the ongoing replenishment round of the Global Fund for 2021–2023. The Global Fund analyzed the cost of bringing the three epidemics of HIV/AIDS, TB and malaria to an end by 2030. For each of the three diseases, detailed costing analyses have been undertaken by the respective global partnerships, including Roll Back Malaria, Stop TB and Joint United Nations Programme on HIV/AIDS (UNAIDS), and the Global Fund combined the cost estimates into an aggregate estimate of funding needs.

The results are summarized in Figure 2. The estimated total financing needed to end the three epidemics by 2030 is estimated to be US\$101 billion for 2021–2023. The US\$101 billion covers the group of countries eligible for Global Fund support. To finance these needs, the Global Fund identifies the sums that can be raised through the domestic budget revenues of the countries themselves, plus the sums that can be expected from donors other than the Global Fund, plus the remainder left to the Global Fund and unidentified sources.

US\$14 billion replenishment plus domestic and other external funding will cover approximately 82% of need of 2021–2023

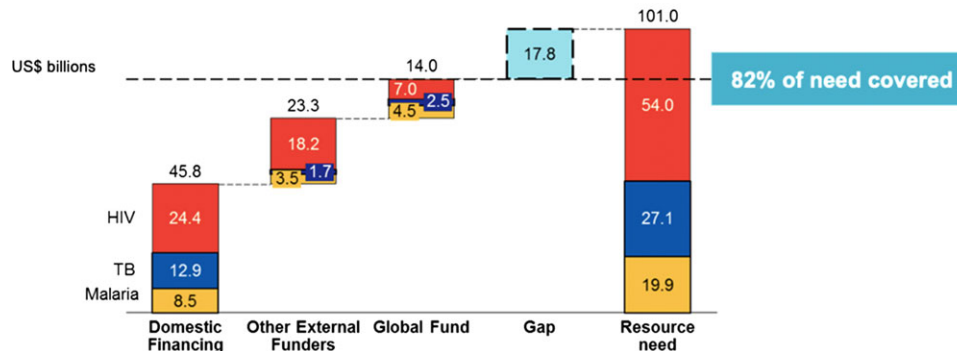


Figure 2. Financing needs and sources for controlling AIDS, TB and malaria. Global Fund to Fight AIDS, TB and Malaria, Investment Case update, 18 January 2019.

As shown in Figure 2, domestic revenues are expected to cover US\$45.8 billion. ‘Other external funders’, already identified, aside from the Global Fund, are expected to cover US\$23.3 billion. That leaves a total of US\$31.8 billion for the Global Fund and unidentified donors (US\$101 billion–US\$45.8 billion–US\$23.3 billion, with rounding). Sadly, the Global Fund is asking for only US\$14 billion of the US\$31.8 billion, while making clear that more than US\$14 billion is needed. Yet the Global Fund’s ‘ask’ of US\$14 billion still leaves a financing gap of US\$17.8 billion with no identified source of funding! The Global Fund indicates that the US\$14 billion plus the other identified sources would cover only 82% of the funding needs. It is not feasible to solve the problem of the three headline epidemics unless the requisite resources are provided.

However, it is important to understand the reason why the Global Fund is asking for less than is needed. The Global Fund was advised by its donors to request only US\$14 billion because that is the amount the donors plan to give. When the Global Fund requests US\$14 billion, and that is what is subsequently delivered by the donors, a ‘success’ can be declared. In other words, the donors seek a triumph of public relations over public health.

The tragedy is that the required incremental funding of US\$31.8 billion over 3 y, amounting to less than US\$11 billion per year, is a tiny sum from a macroeconomic point of view. It amounts to around 5 d of Pentagon spending! It is a mere 0.1% of the US\$10 trillion in net worth of the world’s 2200 billionaires. A modest wealth tax on billionaires of 1% of their net worth would raise around US\$100 billion per year, more than enough to close the entire financing gap for all basic health coverage for all of the LIDCs. In reality, it is a reasonable estimate that an incremental US\$100 billion per year would close not only the financing gap for health but also the financing gap for basic education.

I believe that there will be a political reckoning in the future. When individuals like Jeffrey Bezos have a personal net worth of more than US\$100 billion and see fit to use that wealth to fly to the Moon rather than to save millions of lives on Earth, the ethical failings of our current economic order are grimly revealed. (Bezos could afford to do both, of course). When rich countries like the USA devote a mere 0.17% of gross domestic product to

official development aid, compared with military and other security spending (roughly 30 times more), the immorality of our geopolitics is also revealed. The moral and practical case for taxing rich individuals and nations and investing the incremental proceeds in global health is stronger than ever.

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Competing interests: Jeffrey D. Sachs is University Professor at Columbia University and served as Chairman of the Commission on Macroeconomics and Health for WHO during 2000–2001. He served as Special Advisor to the UN Secretary-General during 2001–2018. The views expressed here are strictly his own.

Ethical approval: Not required.

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