

Has donor prioritization of HIV/AIDS displaced aid for other health issues?

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Advocates for many developing-world health and population issues have expressed concern that the high level of donor attention to HIV/AIDS is displacing funding for their own concerns. Even organizations dedicated to HIV/AIDS prevention and treatment have raised this issue. However, the issue of donor displacement has not been evaluated empirically.

This paper attempts to do so by considering donor funding for four historically prominent health agendas—HIV/AIDS, population, health sector development and infectious disease control—over the years 1992 to 2005. The paper employs funding data from the Organization for Economic Cooperation and Development's (OECD) Development Assistance Committee, supplemented by data from other sources.

Several trends indicate possible displacement effects, including HIV/AIDS' rapidly growing share of total health aid, a concurrent global stagnation in population aid, the priority HIV/AIDS control receives in US funding, and HIV/AIDS aid levels in several sub-Saharan African states that approximate or exceed the entirety of their national health budgets. On the other hand, aggregate donor funding for health and population quadrupled between 1992 and 2005, allowing for funding growth for some health issues even as HIV/AIDS acquired an increasingly prominent place in donor health agendas. Overall, the evidence indicates that displacement is likely occurring, but that aggregate increases in global health aid may have mitigated some of the crowding-out effects.

Keywords Donor aid, HIV/AIDS, health priority-setting, population, health sector development

KEY MESSAGES

- There is evidence that donor prioritization of HIV/AIDS treatment and prevention in developing countries is displacing aid for other health issues.
- Increases in aggregate amounts of aid for global health may have mitigated the extent of this displacement.

It is an unfortunate reality that budgeting procedures too often may mean that new funds for HIV and AIDS can draw resources away from other activities, either at country level, or at donor level. Therefore, all parties need to commit themselves to the principle that additional funding for HIV and AIDS is to be used for

additional spending, otherwise displacement is inevitable to the detriment of overall development.
(UNAIDS, 2004 Report on the global AIDS epidemic)

Introduction

As donor attention to the prevention, control and treatment of HIV/AIDS increases, advocates for other health issues affecting

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the poor have expressed concern that this prioritization may have adversely affected funding for and attention to other health and population issues. Such concerns have been particularly prominent among reproductive health and population scholars and advocates (Berer 2004; Yazbeck 2004; Crossette 2005), although not limited to this group. Those concerned with tobacco control, tuberculosis, child immunization and health sector development, among other issues, have also expressed the same worry (Levin *et al.* 2002; Raviglione and Pio 2002; Furjuoh 2003; Shiffman 2006; Garrett 2007). Even organizations dedicated to HIV/AIDS prevention and treatment have acknowledged a potential problem, as the excerpt above from a 2004 UNAIDS report indicates. One reason this issue has been raised is the large concentration of resources on a disease that, while imposing a high burden, is far from the dominant cause of illness and mortality in low- and middle-income countries. As of 2001, HIV/AIDS represented 5.3% of deaths and 5.1% of disability-adjusted life years in low- and middle-income countries (Lopez *et al.* 2006), figures that have likely not changed significantly since then (UNAIDS 2006).

While concerns have been raised, the precise effects of donor prioritization of HIV/AIDS on donor funding for other health issues have not been examined. In this paper I consider funding from major donors for health and population since the early 1990s in an initial attempt to investigate this issue. I take no normative position on *how* donor health and population resources should be allocated. This research has empirical rather than normative aims. Presumably, though, empirical conclusions from this paper and other research on donor funding may be useful for future policy decision-making.

Background

A number of dynamics may contribute to displacement. Donors have hard-budget constraints. If a donor chooses to augment funding for one issue, it must decrease funding for other issues unless it can secure additional resources (Feeny and McGillivray 2004). Also, bandwagon effects may occur among donors. As influential donors prioritize a particular issue, others may follow, leading to the neglect of other issues (Périn and Attaran 2003). In addition, national health systems have limited human resources. If donors provide extensive funding for one issue, doctors, nurses and other personnel may focus their attention on that issue to the neglect of other problems (Brugha *et al.* 2004; Caines and Lush 2004; Caines *et al.* 2004; Garrett 2007).

On the other hand, if some donors prioritize one issue, others may divert resources to additional issues. National authorities may do the same, a fungibility effect (Devarajan and Swaroop 1998; Waddington 2004). Also, funds provided for a particular issue may build national infrastructure that can support other issues, as advocates of global polio eradication have argued concerning vaccination for other diseases. In addition, global attention to a major health issue such as HIV/AIDS may have helped galvanize international support for the general concern of addressing the health problems of the poor, benefiting other health issues.

The question of displacement implicitly raises a counter-factual: in the absence of the HIV/AIDS epidemic what would

have happened to funding for other health issues? Some HIV/AIDS advocates may presume that money for this issue has been largely additional, with no adverse effect on funding for other health issues or even increasing these amounts by raising levels of concern for the health of the poor in the developing world. In contrast, advocates for other issues may believe that HIV/AIDS moneys have encroached upon a limited pool of funds and taken an unfair share, and that in the absence of the epidemic these issues would have received significantly greater resources. The difficulty in evaluating these competing interpretations is that the counter-factual is unobservable: we cannot rerun history and compare donor funding trends for health and population in the absence of the epidemic with those in the real world where the epidemic exists. For this reason any inferences on the question of displacement must be tentative.

Another reason one must be cautious in drawing inferences is that this study considers only aggregate donor funding. It does not evaluate national health funding in depth, so no firm conclusions can be drawn about donor effects on country-level resources. Also, many factors besides HIV/AIDS prioritization influence funding levels for other health issues, including the burden of particular conditions and the advocacy effectiveness of their champions. A more comprehensive analysis of HIV/AIDS displacement effects requires controlling for these factors. In addition, some funding originally classified as population expenditures (such as support for condoms) may have been re-categorized as HIV/AIDS expenditures. Beyond this, the HIV/AIDS agenda may be influencing other health issues in ways not revealed by funding trends, for instance by diverting donor and national *human* resources toward HIV/AIDS and away from other issues. To investigate displacement more comprehensively we need studies of multiple kinds, including examination of the national and bureaucratic politics of aid provision in industrialized countries, of interactions among donors themselves, and of dynamics within developing countries.

Methods

I calculated the amount of funding for major health and population issues in constant US dollars since 1992 from bilateral and multilateral donors, and from the Gates Foundation, which in the past several years has emerged as one of the world's top five donors for developing-world health (Table 1). I relied on the Credit Reporting System (CRS) database of the OECD's Development Assistance Committee (DAC), an organization that monitors and assesses aid from the world's major bilateral and multilateral donors.¹ The Gates Foundation is not included in the CRS, so I drew on the Foundation's own online database records to calculate funding from that organization for the issues considered in this paper.² I analysed the years 1992 to 2005 since my primary concern was recent rather than historical priorities, and since records for these but not earlier or later years were relatively comprehensive for each of the donors considered.

CRS categories 120 and 130 cover health and population funding, and include commitments from the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States

Table 1 Donors considered

Donor type	Donor
Bilateral	Australia
	Austria
	Belgium
	Canada
	Denmark
	Finland
	France
	Germany
	Greece
	Ireland
	Italy
	Japan
	Luxembourg
	Netherlands
	New Zealand
	Norway
	Portugal
	Spain
	Sweden
	Switzerland
United Kingdom	
United States	
Multilateral	African Development Fund
	Asian Development Fund
	European Commission
	Inter-American Development Bank Special Fund
	Global Fund to Fight AIDS, Tuberculosis and Malaria
	Joint United Nations Program on HIV/AIDS (UNAIDS)
	United Nations Children's Fund (UNICEF)
	United Nations Development Programme (UNDP)
	United Nations Population Fund (UNFPA)
World Bank (IDA)	
Foundation	Bill & Melinda Gates Foundation

President's Emergency Plan for AIDS Relief (PEPFAR). These categories are divided into 15 sub-categories. I grouped these sub-categories into four broad health agendas that historically have been prominent among donors: HIV/AIDS prevention and control, population and reproductive health, the control of infectious diseases other than HIV/AIDS, and health sector development.³ I then examined annual funding figures, comparing HIV/AIDS trends with those of the other agendas.

CRS data have a number of well-known limitations, and at the time of data analysis were relatively complete only to 2005. I therefore considered data from other sources, including UNAIDS reports, US government documents and independent research on donor funding. These data did not fill in existing holes in the CRS, but they did enable me to enlarge the base of information to analyse whether displacement has occurred. Among the limitations of the CRS database are that it is not fully complete as donors do not report all grants and loans;

Table 2 Percentage of health and population commitments from all donors by issue^a

Year	HIV/AIDS	Infectious disease control	Health sector		Total
			development	Population	
1992	7.7	5.0	55.2	32.1	100
1993	3.1	4.6	65.2	27.0	100
1994	10.1	10.9	46.1	32.8	100
1995	9.1	3.2	57.2	30.5	100
1996	4.9	9.7	70.0	15.4	100
1997	5.0	14.4	51.9	28.8	100
1998	5.2	8.3	60.4	26.1	100
1999	11.5	23.4	49.0	16.2	100
2000	19.7	14.7	48.3	17.3	100
2001	25.8	12.8	41.9	19.5	100
2002	21.8	15.8	40.5	22.0	100
2003	35.1	15.7	34.4	14.7	100
2004	29.9	16.2	41.9	12.0	100
2005	23.5	25.6	42.9	8.0	100

Sources: OECD CRS database and Gates Foundation global health grants database. Donors included are all those listed in Table 1.

^aThe decline in the percentage of funding for HIV/AIDS from 2003 to 2005 is associated with multi-year commitments provided in 2003 by the Global Fund and PEPFAR. The rise in percentage of funding for infectious disease control from 2004 to 2005 is associated with a multi-year commitment from the Gates Foundation to GAVI.

each grant is assigned to only one category according to its primary purpose, even if it includes funding for multiple issues; disbursements are poorly covered in the CRS so most analyses must be done on commitments; and the category for HIV/AIDS also includes funding for the control of other sexually transmitted diseases. This being said, the CRS in recent years is relatively complete (Development Assistance Committee 2002), and there is no reason to believe that reporting omissions vary systematically by issue, so comparisons across issues may be reasonably reliable. Also, other studies have concluded that nearly all funding in the STD/HIV category is for HIV/AIDS, and even funding geared toward the control of other sexually transmitted diseases is likely to benefit HIV/AIDS prevention and control (Attaran and Sachs 2001).

Results

Relative aid shares: 1992–2005

HIV/AIDS' relative share of health and population aid has risen rapidly across time (Table 2). In 1992, HIV/AIDS received 7.7% of donor health and population aid; by 2003 it received more than a third of all commitments (35.1%). Percentages for HIV/AIDS declined in 2004 and 2005, most likely because in 2003 two newly launched major global initiatives targeting HIV/AIDS—PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria—made large commitments to cover subsequent years.

Over the same period the percentage of aid for population declined from nearly a third of all funding (32.1%) to just 8.0% in 2005. Health sector development's share also declined,

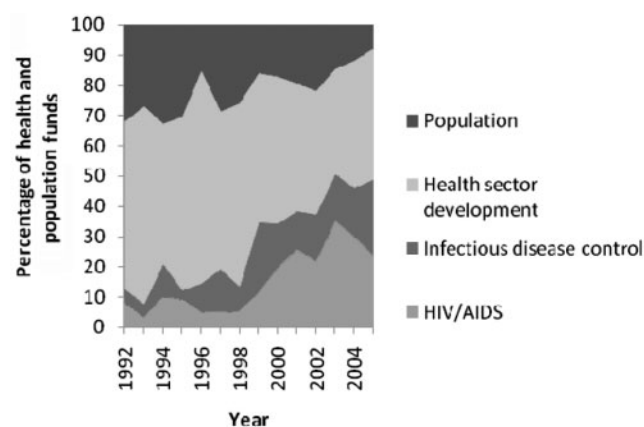


Figure 1 Percentage of health and population commitments from all donors by issue. Sources: OECD CRS database and Gates Foundation global health grants database. Donors included are all those listed in Table 1.

although not as markedly, from 55.2 to 42.9%. Infectious disease control's percentage rose from 5.0% in 1992 to around 15% in the 2000s. In 2005 its share slightly exceeded that of HIV/AIDS, rising to 25.6% from 16.2% in 2004. This increase from 2004 to 2005 was due largely to a 2005 Gates Foundation multi-year commitment of US\$750 million to the Global Alliance for Vaccines and Immunisation (GAVI).

The combined percentage of funding for the two disease-specific categories, HIV/AIDS and infectious disease control, has risen steadily over time, from just 12.7% in 1992 to half of all health and population aid (49.1%) in 2005 (see Figure 1). There has been a corresponding decline in the percentages for health sector development and population. This shift in relative shares toward vertically oriented funding is one of the most noticeable of all trends in donor aid for health and population. This shift is in part due to the appearance in the late 1990s of a major new donor for health and population with a commitment to the control of HIV/AIDS and other infectious diseases, the Gates Foundation. However, these trends stand even if we exclude the Gates Foundation. From 1992 to 2005 for all donors except Gates, the percentage of total aid for health and population devoted to HIV/AIDS and other infectious diseases rose from 12.7 to 43.1%.

Donors vary considerably in the extent to which they prioritize HIV/AIDS (Figure 2). The five largest donors for health and population in recent years (aside from the Global Fund to Fight AIDS, Tuberculosis and Malaria which by organizational mandate concentrates on HIV/AIDS and these two other infectious diseases) were in rank order: the United States, the World Bank, the Gates Foundation, the United Kingdom and the European Commission. They committed 57.3% of funds for health and population from 2003 to 2005 among the 33 donors considered in this study. The United States devoted the highest percentage of its funds to HIV/AIDS over this time period, 41%. The United Kingdom and the World Bank also allocated a significant share to HIV/AIDS: 30% and 27%, respectively. The Gates Foundation's resources for HIV/AIDS were considerably less than those for other infectious diseases. The European Commission devoted little of its funds to HIV/AIDS.

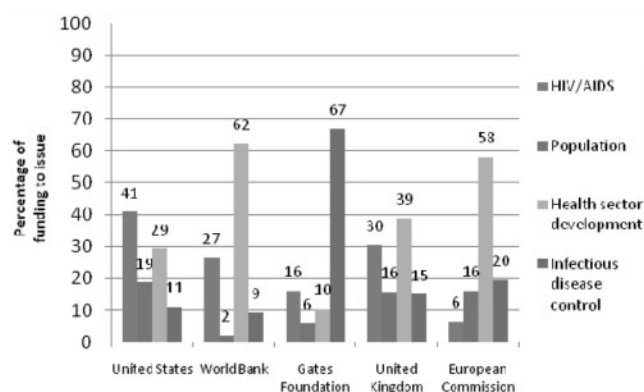


Figure 2 How the five largest donors for health and population allocate their funding: percentages to each of four issues over the period 2003–05. Sources: OECD CRS database and Gates Foundation global health grants database.

Table 3 Health and population commitments from all donors by issue (in millions of constant US dollars, 2004 base year)

Year	HIV/AIDS	Infectious disease control	Health sector development	Population	Total
1992	213	139	1531	890	2774
1993	92	137	1937	803	2969
1994	336	363	1528	1088	3314
1995	305	108	1923	1025	3361
1996	176	350	2529	557	3613
1997	198	572	2063	1145	3977
1998	265	417	3050	1318	5050
1999	658	1338	2804	925	5726
2000	1268	947	3105	1114	6435
2001	1445	716	2351	1094	5606
2002	1542	1117	2873	1558	7090
2003	3116	1394	3050	1306	8866
2004	2718	1478	3808	1090	9094
2005	2614	2846	4761	887	11 107

Sources: OECD CRS database and Gates Foundation global health grants database. Donors included are all those listed in Table 1.

Absolute aid shares: 1992–2005

From 1992 to 2005 funding for HIV/AIDS rose rapidly not only in relative but also in absolute terms (Table 3). In constant US dollars it increased more than twelve-fold from \$213 million to \$2.6 billion, an average annual growth rate of 41.8% [over the same time period the number of adults globally living with HIV rose approximately four-fold from around 10 million to 38.6 million (UNAIDS 2006)]. However, because the pool of overall funds for health and population quadrupled from \$2.8 billion to \$11.1 billion, other issues also benefited. Funding for health sector development, while declining as a relative share of health and population aid, more than tripled in constant dollar terms from \$1.5 billion to nearly \$4.8 billion. Infectious disease control funding rose from \$139 million to \$2.8 billion. Only population fared poorly, remaining largely stagnant in constant dollar terms with approximately the same amount in 1992 (\$890 million) as in 2005 (\$887 million).

Trends since 2005

Since 2005 a significant rise in commitments for HIV/AIDS, largely from the United States, likely has increased HIV/AIDS' relative share of total donor aid for health and population.⁴ President Bush announced the President's Emergency Plan for AIDS Relief (PEPFAR) in his January 2003 State of the Union address, a five-year, \$15 billion global initiative. By 2006 funding for HIV/AIDS had reached approximately 80% of US aid for health and population (Global Health Council 2007), the highest percentage in history. Meanwhile, US funding for other health and population issues stagnated in absolute terms (Global Health Council 2007).

Recent developments indicate that US prioritization of HIV/AIDS is likely to continue. For the 2007 fiscal year the US government appropriated \$4.5 billion for HIV/AIDS, which received the largest increase of any item in the entire US international affairs budget (US Congress 2007; US Global Leadership Campaign 2007). By comparison, the United States committed less than one billion dollars for HIV/AIDS control in 2005, according to CRS data. For the 2008 fiscal year President Bush requested approximately \$5.4 billion for HIV/AIDS (Global Health Council 2007). In May 2007 President Bush announced his intention to seek re-authorization of PEPFAR, requesting \$30 billion for HIV/AIDS over a period of 5 years (United States President's Emergency Plan for AIDS Relief 2007).

Other donors also are increasing commitments for HIV/AIDS. Prior to the G8 summit in June 2007, Germany committed US\$5.4 billion for HIV/AIDS for the period 2007 to 2015. A Kaiser Foundation/UNAIDS analysis reports that although funds for the disease were still inadequate, international commitments for HIV/AIDS from the G8, European Community and other donor governments reached a higher level in 2006 than ever in the past: US\$5.6 billion (Kates *et al.* 2007).

HIV/AIDS aid and national health budgets

Another indicator of donor prioritization of HIV/AIDS is the amount of funding relative to recipient country health budgets (Table 4), an issue of particular import given limited absorptive capacity in many developing countries. In several sub-Saharan African states with low to moderate HIV prevalence levels, donor funding for HIV/AIDS was comparable to or exceeded the amounts allocated by the national government to the entire health sector (Bernstein and Sessions 2007). In Ethiopia, for instance, with an HIV prevalence rate of 1.4%, donors committed US\$130 million for HIV/AIDS in 2005, compared with a 2003 national health budget (the latest year for which data are available) of US\$113 million. Commenting on this issue in Rwanda, a government report noted 'a gross misallocation of resources' in the health sector, stating that 'the main problem is the development partners' (Ministry of Finance and Economic Planning, Ministry of Health, Republic of Rwanda 2006, p. 8). As one piece of evidence for misallocation, the report pointed to, '\$18mn earmarked for malaria (the biggest cause of mortality and morbidity) and just \$1mn for the integrated management of childhood illnesses, compared to \$47mn for HIV/AIDS, grossly disproportionate in a country with a 3% infection rate'.

Table 4 National health budgets and donor HIV/AIDS commitments in three African countries

Country	HIV prevalence rate (adults aged 15 to 49)	National health budget fiscal year 2003 (millions US dollars) ^a	Donor HIV/AIDS commitments 2005 (millions US dollars)
Ethiopia	1.4%	113	130
Rwanda	3.1%	37	47
Uganda	6.7%	112	167

^a2003 is the latest year for which reliable figures exist on national health budgets for these countries.

HIV prevalence sources: Ethiopia (Central Statistical Agency [Ethiopia] and ORC Macro 2006); Rwanda (UNAIDS 2007a); Uganda (UNAIDS 2007b).

National health budget sources: Ethiopia (Ministry of Finance and Economic Development, Ethiopia 2003, as reported in Bernstein and Sessions); Rwanda (Ministry of Health, Republic of Rwanda 2006); Uganda (Ministry of Finance, Planning and Economic Development, Republic of Uganda 2003, as reported in Bernstein and Sessions).

Donor HIV/AIDS commitments sources: Ethiopia (Bernstein and Sessions 2007); Rwanda (Ministry of Finance and Economic Planning, and Ministry of Health, Republic of Rwanda 2006); Uganda (Bernstein and Sessions 2007). For Ethiopia and Uganda, HIV/AIDS commitments are totals from the three largest HIV/AIDS donors in these countries, which encompass almost all HIV/AIDS commitments: PEPFAR, the Global Fund and the World Bank's Multi-Country AIDS Program.

Conclusion

Several trends indicate possible HIV/AIDS displacement effects on other health issues: its rapidly rising percentage of donor health and population funds through 2005; commitments since 2005 that indicate a continuation of this pattern; its dominant place in the agenda of the world's largest donor for health, the United States; and the flood of moneys into several sub-Saharan African states with low to moderate HIV prevalence. On the other hand, the growing pool of donor funds for health and population has allowed for growth for all major issues except population, a trend that may have mitigated possible displacement effects.

As noted above, one must be cautious in making inferences about displacement. We cannot know how funding trends would have evolved in a world without HIV/AIDS, the implicit counter-factual in claims about crowding-out. Also this study considers only one dimension of the issue, aggregate donor funding. A comprehensive investigation of possible displacement would require studies of multiple types, including effects at national levels and impact not just on financial but also human resources.

These limitations notwithstanding, donor funding trends for HIV/AIDS vis-à-vis other health issues are worth continuous monitoring. HIV/AIDS has risen rapidly to prominence in donor health agendas. There is a need to ensure that as this epidemic is addressed, funding and attention for other major sources of illness and death in developing countries are not neglected.

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Endnotes

- ¹ Available at: <http://stats.oecd.org/WBOS/Default.aspx?DatasetCode=CRSNEW>.
- ² I calculated amounts for grants for HIV/AIDS, population, health sector development and infectious disease control from the online database, available at: <http://www.gatesfoundation.org/GlobalHealth/>.
- ³ HIV/AIDS is purpose code 13040 (STD control including HIV/AIDS); population and reproductive health are purpose codes 13010 (population policy and administrative management), 13020 (reproductive health care), 13030 (family planning) and 13081 (personnel development for population and reproductive health); infectious diseases is purpose code 12250 (infectious disease control); and health sector development is purpose codes 12110 (health policy and administrative management), 12181 (medical education/training), 12182 (medical research), 12191 (medical services), 12220 (basic health care), 12230 (basic health infrastructure), 12240 (basic nutrition), 12261 (health education) and 12281 (health personnel development).
- ⁴ It is not possible to compare funding levels across health and population issues after 2005, since the only comprehensive information source with comparative data—the OECD Credit Reporting System—was up-to-date only to that year at the time of data analysis. Therefore one cannot be certain that HIV/AIDS' relative share has increased. However, given the size of the increase in HIV/AIDS commitments since 2005, funding commitments for the other issues would have had to rise at unprecedented rates to sustain their relative shares.

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