

Financing Global Health 2025

Cuts in Aid and Future Outlook



Institute for Health
Metrics and Evaluation

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INSTITUTE FOR HEALTH METRICS AND EVALUATION
UNIVERSITY OF WASHINGTON

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Institute for Health Metrics and Evaluation
Hans Rosling Center for Population Health
3980 15th Ave. NE
Seattle, WA 98195
USA
www.healthdata.org

To request copies of this report, please
contact IHME:

Telephone: +1-206-897-2800
Fax: +1-206-897-2899
Email: engage@healthdata.org

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Acronyms

AI	Artificial intelligence
CDC	Centers for Disease Control and Prevention
DAH	Development assistance for health
FCDO	Foreign, Commonwealth and Development Office
GDP	Gross domestic product
GNI	Gross national income
NGO	Non-governmental organization
ODA	Official development assistance
OECD	Organisation for Economic Co-operation and Development
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
UNICEF	United Nations Children's Fund

Research team

Angela E. Apeagyei, PhD
Enis Bariş, MD, PhD
Joseph L. Dieleman, PhD
Hans Elliott, MS
Katherine Leach-Kemon, MPH
Brendan Lidlal-Porter, MA
Christopher J.L. Murray, MD, DPhil
Seong Nam, MS
Carolyn Shyong, MPS
Golsum Tsakalos, MS
Bianca Zlavog, MS

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About IHME

An independent population health research organization based at the University of Washington School of Medicine, the Institute for Health Metrics and Evaluation (IHME) works with collaborators around the world to develop timely, relevant, and scientifically valid evidence that illuminates the state of health everywhere. In making our research available and approachable, we aim to inform health policy and practice in pursuit of our vision: all people living long lives in full health. For more information about IHME and its work, please visit www.healthdata.org.

Call for Collaborators

In addition to conducting the Financing Global Health study, IHME coordinates the Global Burden of Diseases, Injuries, and Risk Factors (GBD) Study, a comprehensive effort to measure epidemiological levels and trends worldwide. (More information on GBD is available at <https://www.healthdata.org/research-analysis/gbd>.) The GBD study relies on a network of more than 16,500 Collaborators in 167 countries and territories. Current Collaborator areas of expertise include epidemiology, public health, demography, statistics, and other related fields. IHME has expanded the scope of GBD to encompass quantification of health resource flows, health system attributes, and the performance of health systems. To that end, IHME is seeking GBD Collaborators who are experts in health financing and health systems. GBD Collaborators – many of whom have co-authored GBD or Financing Global Health publications – provide timely feedback related to the interpretation of GBD and Financing Global Health results, data sources, and methodological approaches pertaining to their areas of expertise. We invite researchers and analysts with expertise in health financing to join the GBD Collaborator Network. Potential Collaborators may apply at <https://gbdcollaboratorportal.healthdata.org/aspx/application>.

Executive summary

IHME's *Financing Global Health* report tracks the world's investments in health, with a focus on funding for improving health in low- and middle-income countries. This year's report provides preliminary estimates of development assistance for health, which dropped by 21% between 2024 and 2025 from \$49.6 billion to \$39.1 billion. Forecasts indicate that development assistance for health is likely to decline even more over the next five years, to reach \$36.2 billion in 2030. As many development partners cut their spending, there is a need for new approaches.

Decades of health gains at risk as global health funding drops

As major health crises have emerged over the last three decades – from HIV/AIDS to COVID-19 – development partners have responded by investing record-breaking amounts in fighting these diseases. Among many other things, this funding has been instrumental in driving down the rate of deaths from HIV/AIDS by nearly two-thirds since 2003. Now, however, many development partners are pulling back, particularly the US – IHME estimates the US government reduced its funding by 67%, more than \$9 billion, in 2025. These cuts threaten to undo the global health progress that the world has made to date. In contrast, some funders, such as Australia and Japan, have maintained or slightly increased their development assistance for health contributions (increases of 2.6% [\$18.2 million] by Australia and 2.2% [\$30.4 million] by Japan).

Sub-Saharan African countries and NGOs facing steep cuts

Amid the steep drops in development assistance for health, countries in Eastern, Central, Southern, and Western sub-Saharan Africa are expected to witness the largest declines in health spending, especially Malawi, the Gambia, Lesotho, and Mozambique. Among global health organizations, estimates indicate that funding has decreased the most among NGOs and UN agencies. Contrary to these trends, IHME's preliminary estimates show that funding from the Gates Foundation, the World Bank, and regional development banks remains relatively constant.

Low- and middle-income countries unlikely to fill funding gaps

Health spending in some of the most under-resourced settings in the world remains extremely low. For example, in 2025, health spending in high-income countries was 299 times greater than in low-income countries. IHME forecasts that these disparities will increase over the next five years.

This report provides estimates of global health spending based on publicly available data as of June 25, 2025.

Introduction

Sharp declines in global health funding

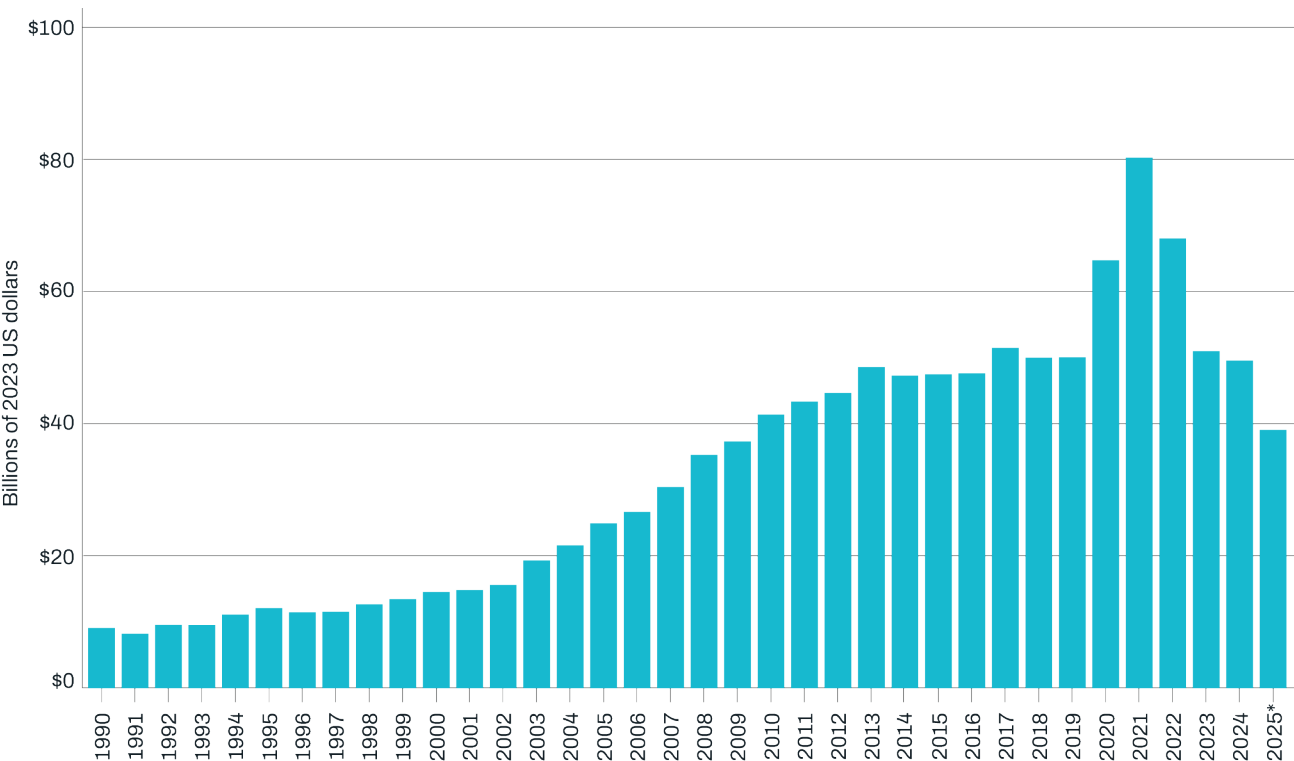
In the first decade of the 21st century, funding for improving and maintaining health in low- and middle-income countries – known as development assistance for health (DAH) – more than tripled. In parallel, deaths among children and people living with HIV/AIDS plunged. Then, development assistance funding increased slightly between 2011 and 2019, and global health progress continued, with deaths among children under 5 in low-income countries dropping from 1,837 per 100,000 in 2011 to 1,485 per 100,000 in 2019, a 19% decline.¹ When COVID-19 emerged, threatening the health and well-being of the entire world, DAH rose to record heights, reaching \$80.3 billion in 2021, helping nations protect their people. Now, in 2025, major development partners have scaled back their DAH, putting lives at risk and jeopardizing the health progress that countries have made to date.

This report's peer-reviewed foundation

The work presented in *Financing Global Health 2025* draws in part on a peer-reviewed research article published on July 15, 2025:

[Tracking development assistance for health, 1990–2030: historical trends, recent cuts, and outlook](#)

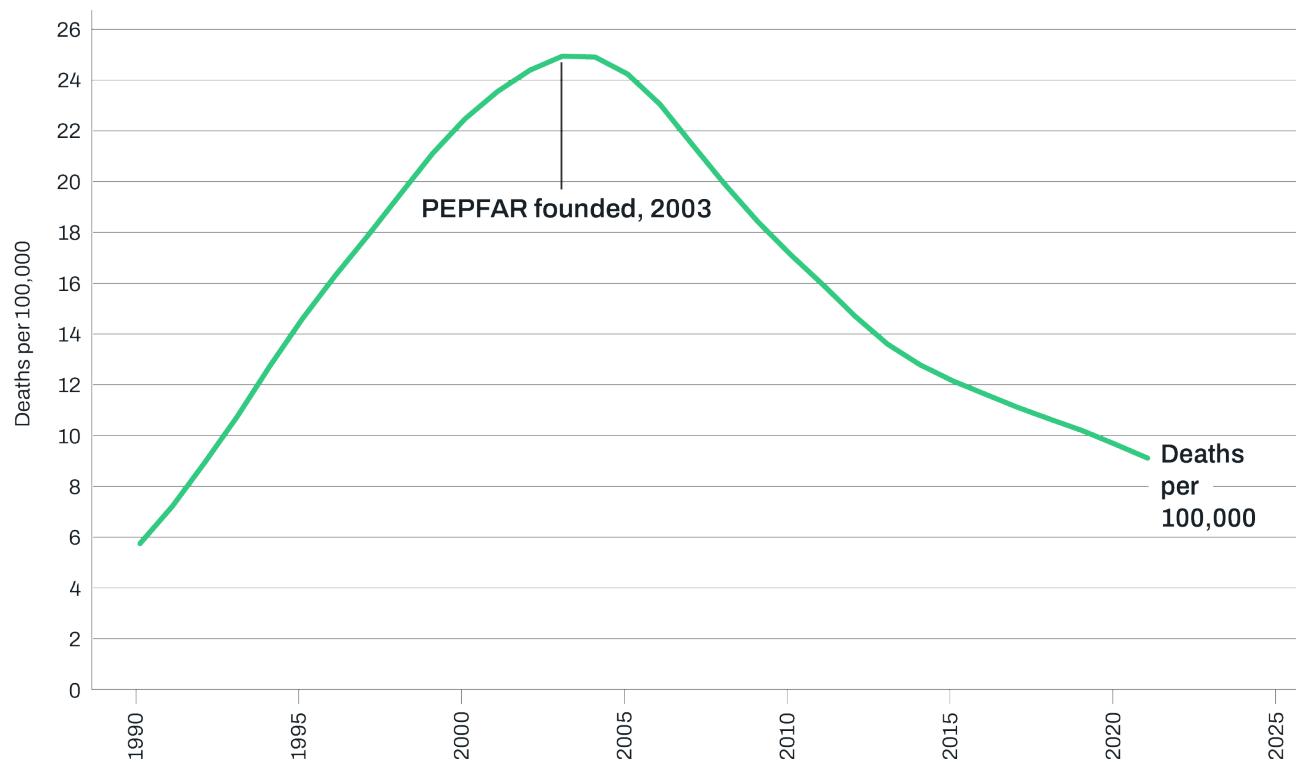
Figure 1: Development assistance for health, 1990–2025



Development assistance for health is measured in 2023 real US dollars.

*2025 estimates are preliminary.

Figure 2: HIV/AIDS global deaths per 100,000 people, 1990–2021



Source: vizhub.healthdata.org/gbd-compare, accessed June 25, 2025

PEPFAR stands for the U.S. President's Emergency Plan for AIDS Relief.

In 2025, IHME's preliminary estimates indicate that DAH has fallen to levels not seen for over 15 years, to \$39.1 billion. DAH dropped by more than one-fifth between 2024 and 2025. For perspective, DAH is now less than half the size it was during the pandemic's peak in 2021, when the world rallied to help countries during the global health emergency.

Declining DAH is just one of the economic challenges that low-income countries have faced recently. Many of these countries have been paying back the loans they took out to protect lives and livelihoods amid COVID-19.² They have been grappling with a steep increase in interest rates, which has made it more expensive to repay their loans.² In addition, governments are facing slowing economic growth as well as inflation and tariffs.³

What's new in FGH 2025?

IHME has been publishing *Financing Global Health* since 2009. The innovations in this year's report include the following:

Visualizing the impact of cuts from major development partners

- We examine how the cuts that development partners announced in late 2024 and early 2025 would reduce the amount of funding invested in improving health in low- and middle-income countries.

Anticipating what the future holds

- IHME has created new forecasts to show how the trajectory of global health funding could evolve over the next five years under current policies.

Tracking contributions from newly added development partners

- For the first time, IHME is tracking contributions from Czechia, Estonia, Hungary, Iceland, Lithuania, Poland, Slovakia, and Slovenia.

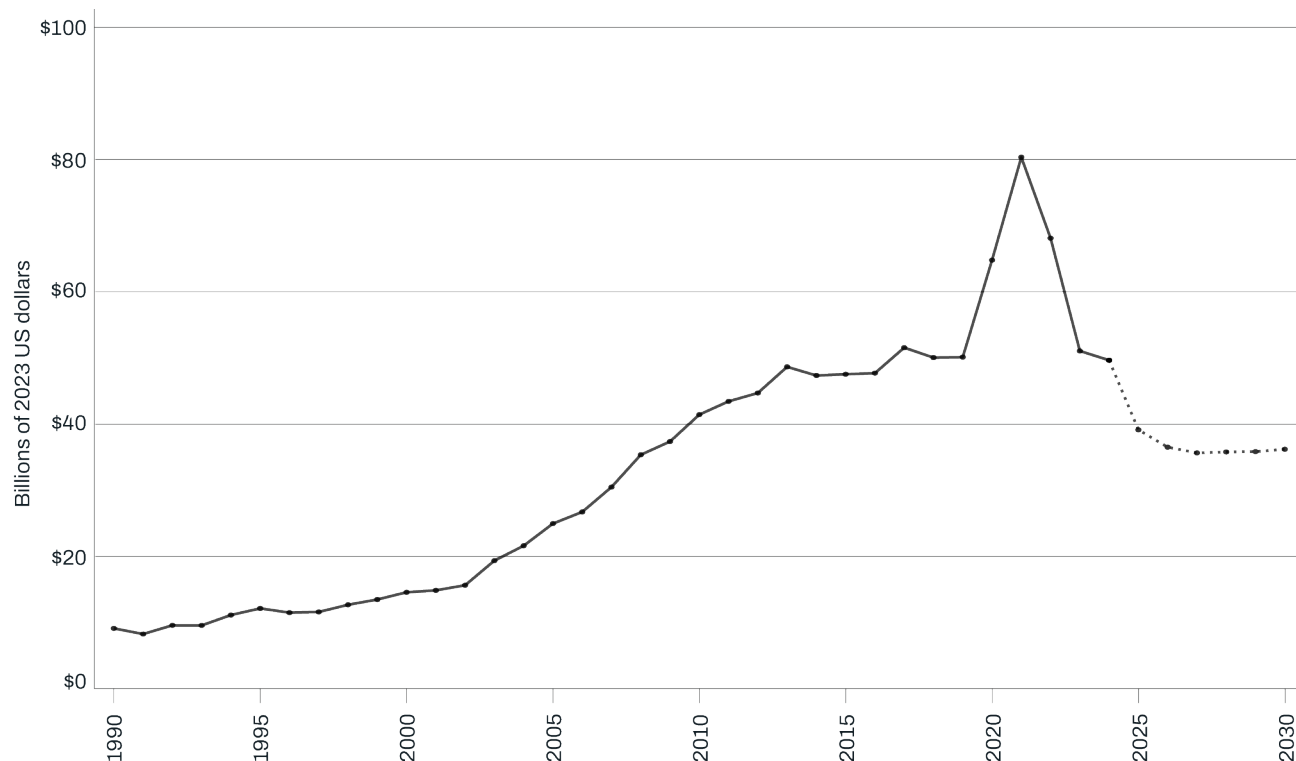
Downward trends in funding likely to continue

The decline in DAH is likely to continue over the next five years according to IHME's forecasts, decreasing by approximately 7.5% over this period. These forecasts take into account the spending targets that funders have recently announced.

The leading development partners have justified their cuts in DAH by citing the need to increase defense spending amid the Russia–Ukraine war. For example, the UK recently cut its development assistance and raised its military spending to the highest levels since the Cold War, citing threats to its national security.⁴

Also, in reducing development assistance, development partners have pointed to the need to redirect resources within their borders to resettling people who are migrants.^{5,6}

Figure 3: Total development assistance for health, 1990–2030

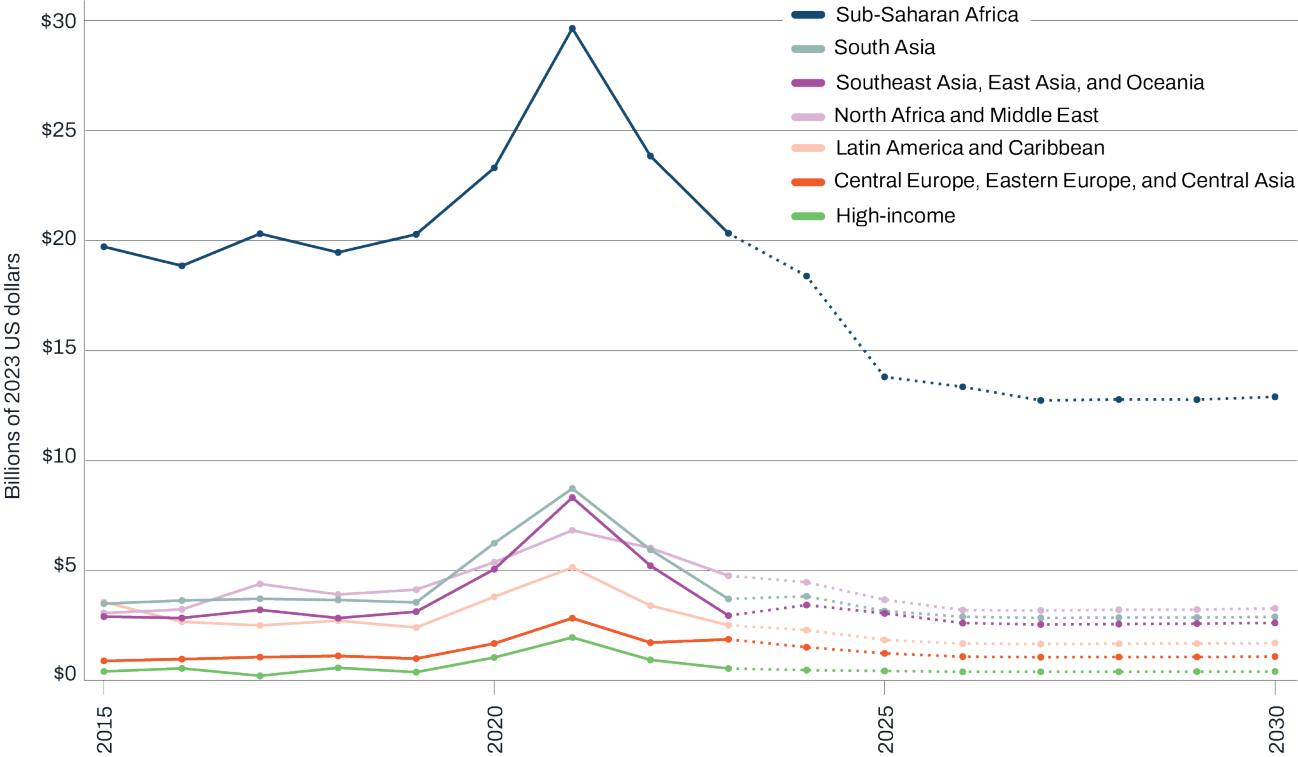


Development assistance for health is measured in 2023 real US dollars, with 2025 being preliminary estimates and 2026 through 2030 estimates being forecasted.

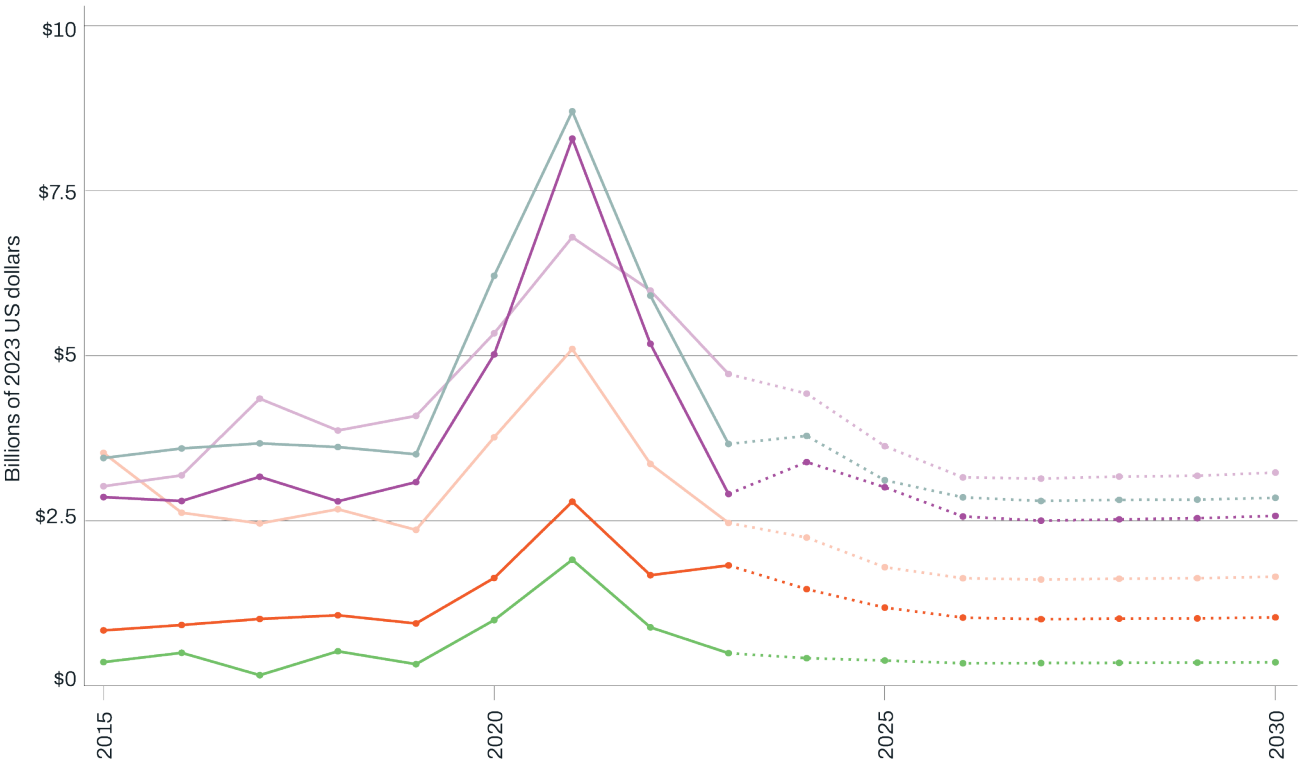
Sub-Saharan Africa hardest hit by cuts over time

As the region receiving the largest amount of DAH, sub-Saharan Africa will experience the largest cuts according to IHME's preliminary estimates, with DAH declining by 25% (\$4.6 billion) between 2024 and 2025 and dropping by an additional 6.6% (\$0.9 billion) from 2025 to 2030. After sub-Saharan Africa, North Africa and the Middle East, South Asia, and Latin America and the Caribbean are seeing the next-largest reductions in DAH. This profound shift in DAH marks a sharp contrast to the US's founding of the President's Emergency Plan for AIDS Relief (PEPFAR) in 2003. When PEPFAR was established with support from the two major political parties, it aimed to reverse the AIDS epidemic in African and Caribbean countries.⁷

Figure 4: Development assistance for health by GBD super-region, 2015–2030



Excluding sub-Saharan Africa



Development assistance for health is measured in 2023 real US dollars, with 2024 through 2030 estimates being forecasted.

Major funders reduce spending while others maintain their support

According to the most recent data available, many countries reduced their investments in global health in 2025. Finland, France, Germany, the UK, and the US have cut their DAH. In contrast, at the time of writing this report, DAH from other countries, including Canada, China, and the United Arab Emirates has stayed steady in 2025, while Japan, Australia, and South Korea increased their DAH slightly.

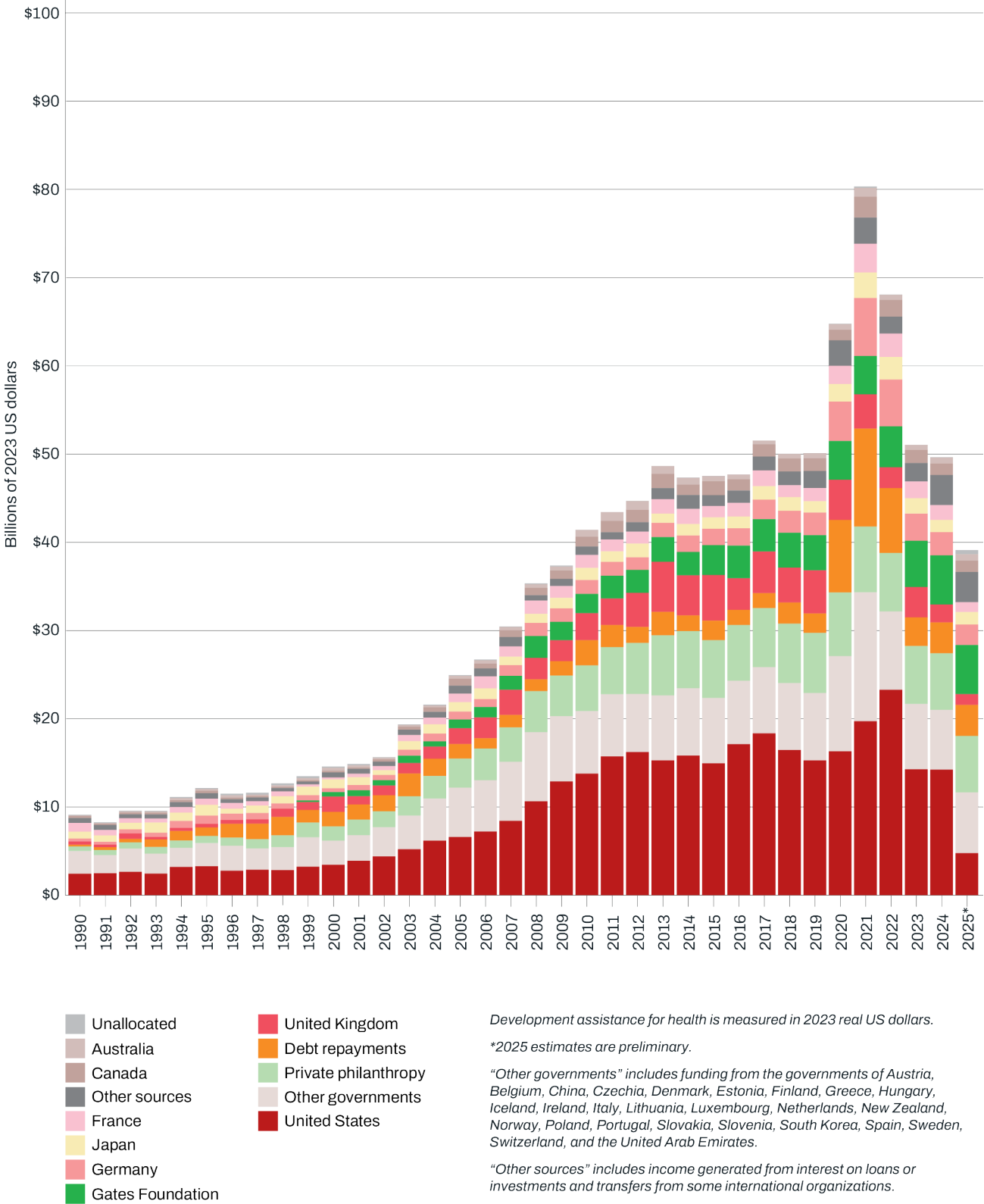
Some countries, including France, have reduced their investments in global health in response to internal pressure and domestic concerns about the effectiveness of this spending.⁸ Other countries, including Germany and the UK, are reducing DAH as they ramp up spending on domestic priorities, such as bolstering defense.^{4,9}

In contrast, Japan increased its DAH from \$1.38 billion to \$1.41 billion – a 2% increase – between 2024 and 2025. The country is focusing on helping low- and middle-income countries expand access to high-quality, effective health care through universal health coverage.¹⁰ Another development partner, Canada, maintained its DAH from 2024 to 2025. This steady funding reflects the Canadian government's 10-year commitment, spanning the years 2020 to 2030, to promote the health and rights of women and girls globally.¹¹

Some development partners have shifted and/or increased their DAH investments in direct response to the US cuts. When the US announced its plans to reduce development assistance, Australia declared that it would help strategically important countries – nations in the Pacific and Southeast Asia – fill their funding gaps.¹² As a result, Australia's DAH increased. However, while allocating more money to countries of strategic interest, Australia shifted funding away from other organizations, such as the Global Fund.¹²

China is another country that changed its global health investment strategy in response to the US government's cuts. In May 2025, China announced that it would provide an additional \$500 million to WHO in response to the US's withdrawal from the organization.¹³

Figure 6: Development assistance for health by source, 1990–2025



Focusing on government funding exclusively, cuts from the US government alone have been the largest in volume terms, with US DAH dropping by more than \$9 billion in 2025 (a 67% decline), followed by cuts from the UK (\$796.1 million, a 39% decline), France (\$555.1 million, a 33% decline), and Germany (\$304.5 million, a 12% decline).

In contrast to the large shifts in DAH from governments, private sector DAH continues to flow. Funding from private philanthropy including the Gates Foundation stayed constant between 2024 and 2025. The Gates Foundation is one of the largest funders of WHO and Gavi. In another important development, in spring 2025, Bill Gates announced that his Foundation would give away his fortune over the next two decades and that he would spend most of that money helping the African continent.¹⁴

Foundations outside of the US are playing an increasingly important role in global health. In the United Arab Emirates, the Mohamed Bin Zayed Foundation for Humanity is contributing to a fund totaling nearly \$500 million that aims to improve maternal and child health in 10 countries in sub-Saharan Africa: Ethiopia, Ghana, Kenya, Lesotho, Malawi, Nigeria, Rwanda, Tanzania, Uganda, and Zimbabwe.¹⁵

Figure 5: Total development assistance for health from major donor countries, 1990–2025

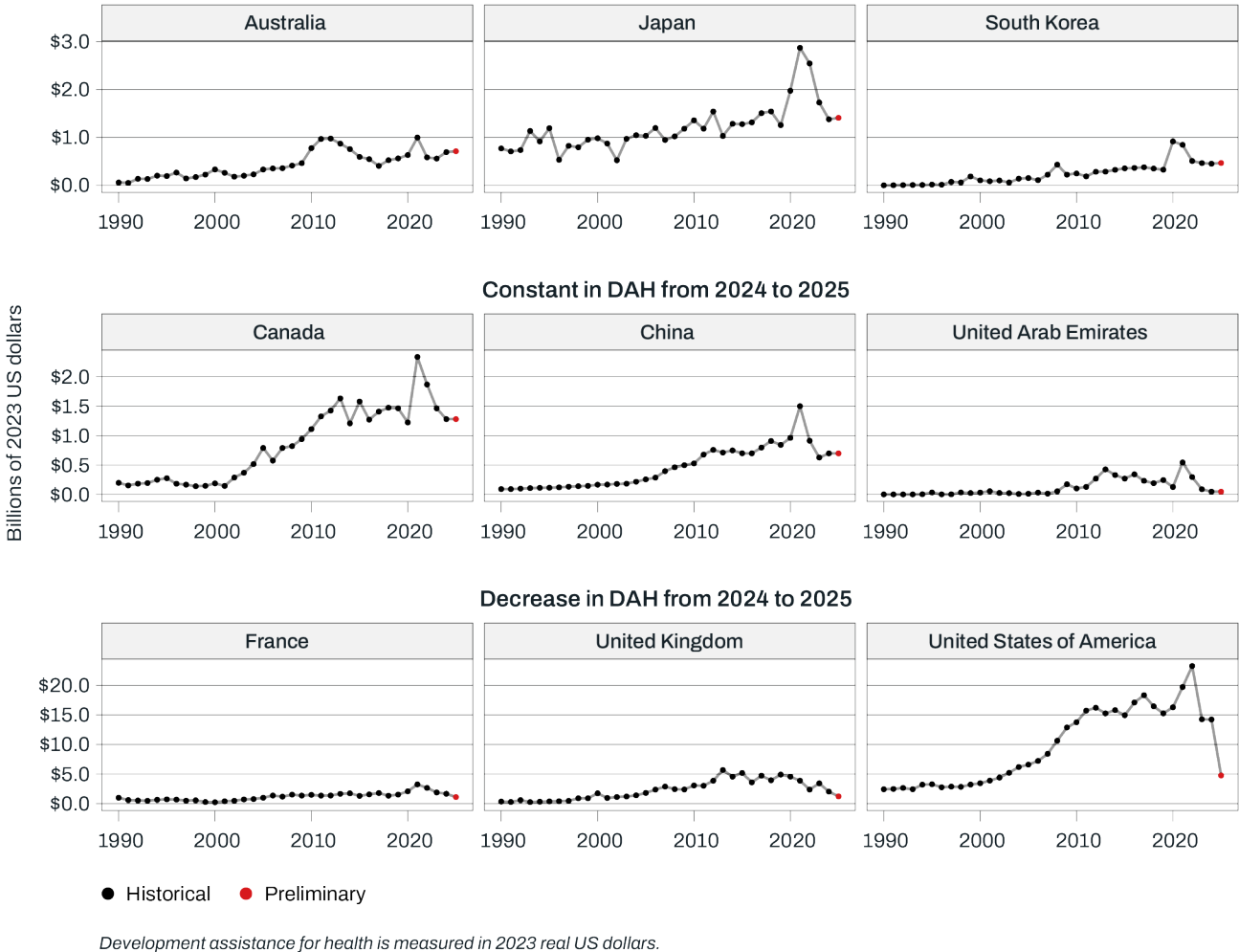
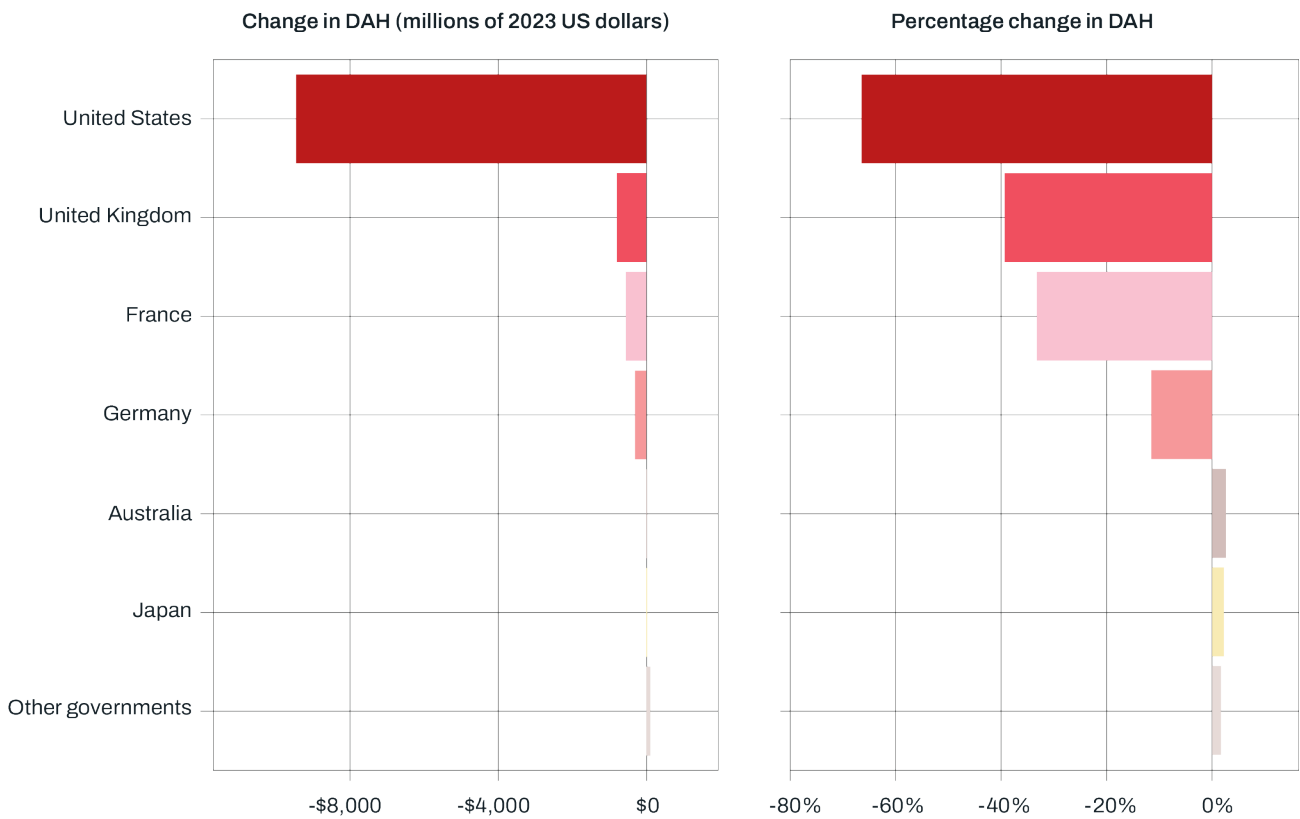


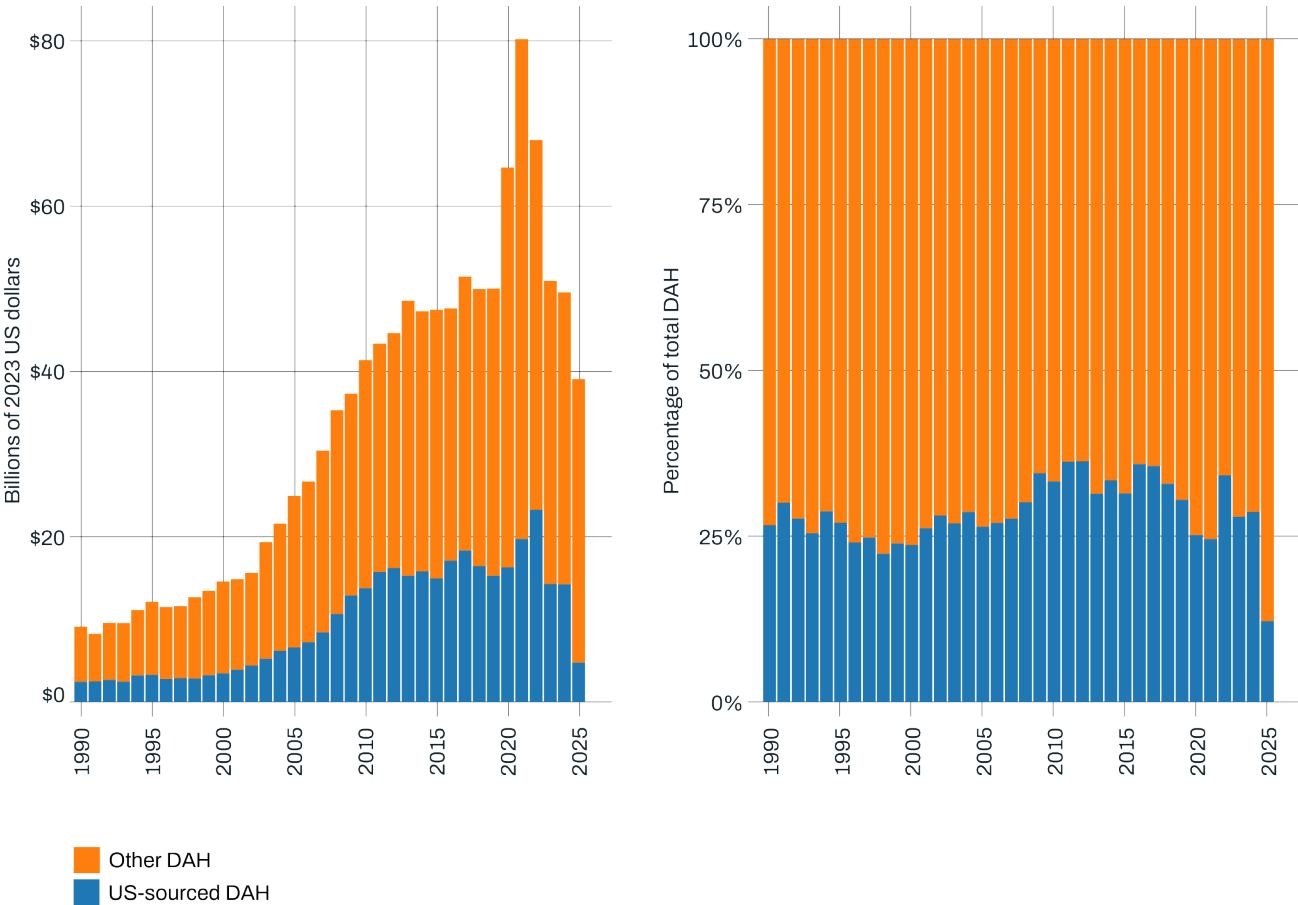
Figure 7: Change in development assistance for health by source, 2024–2025



Development assistance for health is measured in 2023 real US dollars, with 2025 being preliminary estimates.

As far back as 1990, the first year for which IHME tracks DAH, the US government has been the largest source of funding overall, providing more than one-quarter of total funding. After cutting its development assistance budget in 2025, funding from the US government dropped to 12% of total DAH. Now, in 2025, for the first time, IHME’s preliminary estimates suggest that the Gates Foundation has surpassed the US government as the largest individual source of funding for DAH.

Figure 8: US-sourced development assistance for health vs. other development assistance for health, 1990–2025



Development assistance for health is measured in 2023 real US dollars, with 2025 being preliminary estimates.

Other DAH includes all DAH that comes from a source other than the US government. For example, it includes DAH from other governments and private philanthropy.

Who and where are those most affected by these cuts?

Organizations most affected by declining global health funding

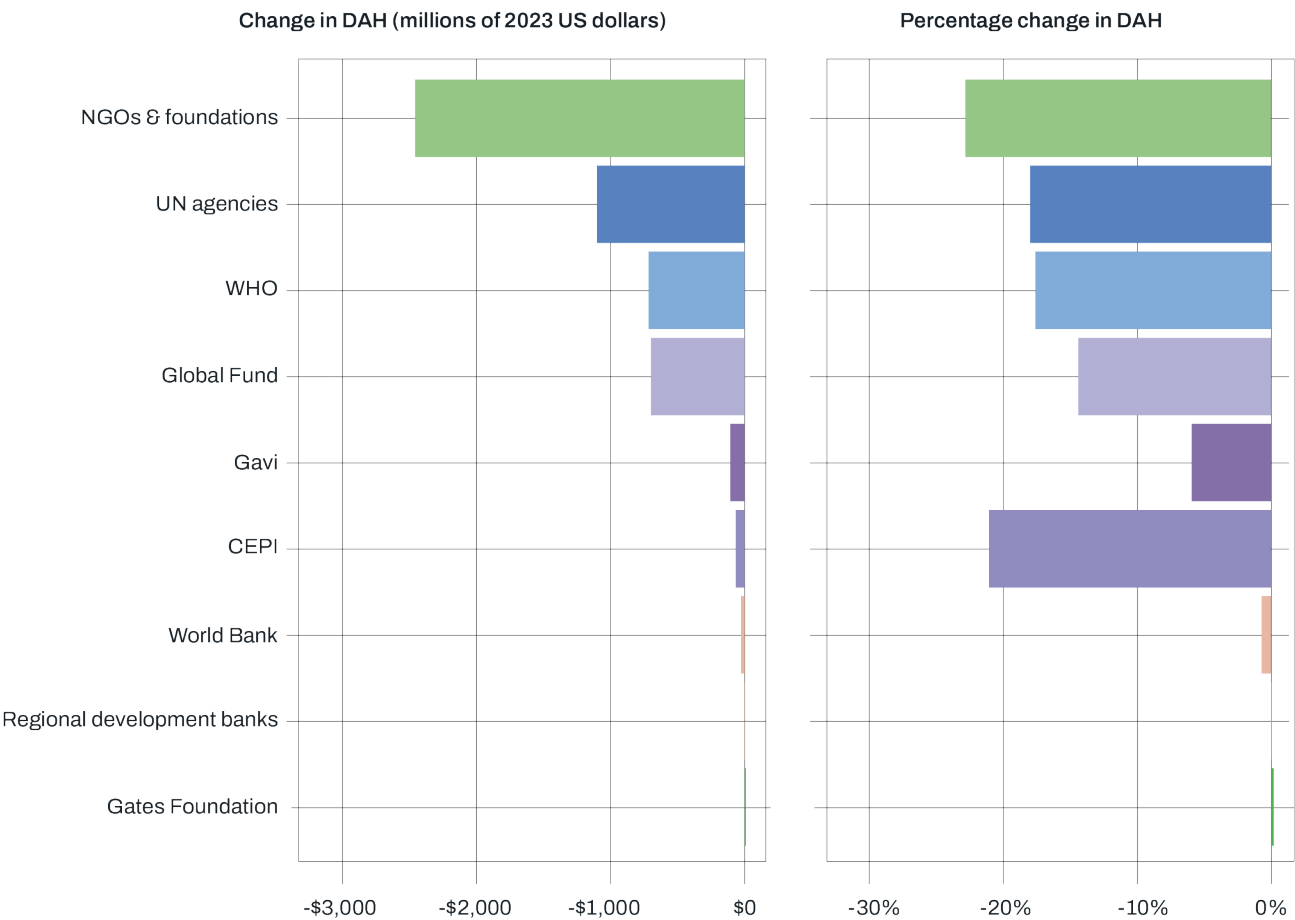
At an institutional level, the disbursing entities (excluding bilateral agencies) that will experience the biggest drops in funding according to IHME estimates include NGOs, as many had received funding from the US government. After NGOs, UN agencies and WHO – which IHME tracks separately from the UN – will see the next-largest decreases in funding.

While many organizations have seen their expected funding drop in 2025, IHME's estimates indicate that – so far – DAH from the World Bank has remained relatively stable. This is because most of its resources come from longstanding commitments or debt repayments. Funding from regional development banks also stayed steady.

The Global Fund is hosting a pledging meeting later this year, and IHME will update its estimates based on which development partners commit to funding the organization. The Global Fund aims to raise \$18 billion to finance its operations through 2029.¹⁶ Norway was the first government to declare its pledge for this fundraising cycle, and the governments of Spain and Luxembourg also announced plans to increase their giving to the Global Fund.^{17,18} On the private side, Japanese pharmaceutical company Takeda and the UK-based Children's Investment Fund have made pledges.^{19, 20}

Another major pledging meeting already occurred in 2025. Gavi, the Vaccine Alliance, held its fundraising meeting on June 25, 2025, securing resources for its work over the next five years. The organization raised a total of \$9 billion, falling short of the \$11.9 billion it originally sought.²¹ The US declined to give any funding to Gavi, while other countries contributed for the first time, including Uganda and Indonesia.²² In the past, Gavi had invested funding in Uganda and Indonesia.

Figure 9: Changes in development assistance for health from 2024 to 2025 among disbursing entities, excluding bilateral agencies



Development assistance for health is measured in 2023 real US dollars, with 2025 being preliminary estimates.

NGOs = non-governmental organizations
 UN = United Nations
 WHO = World Health Organization
 CEPI = Coalition for Epidemic Preparedness Innovations

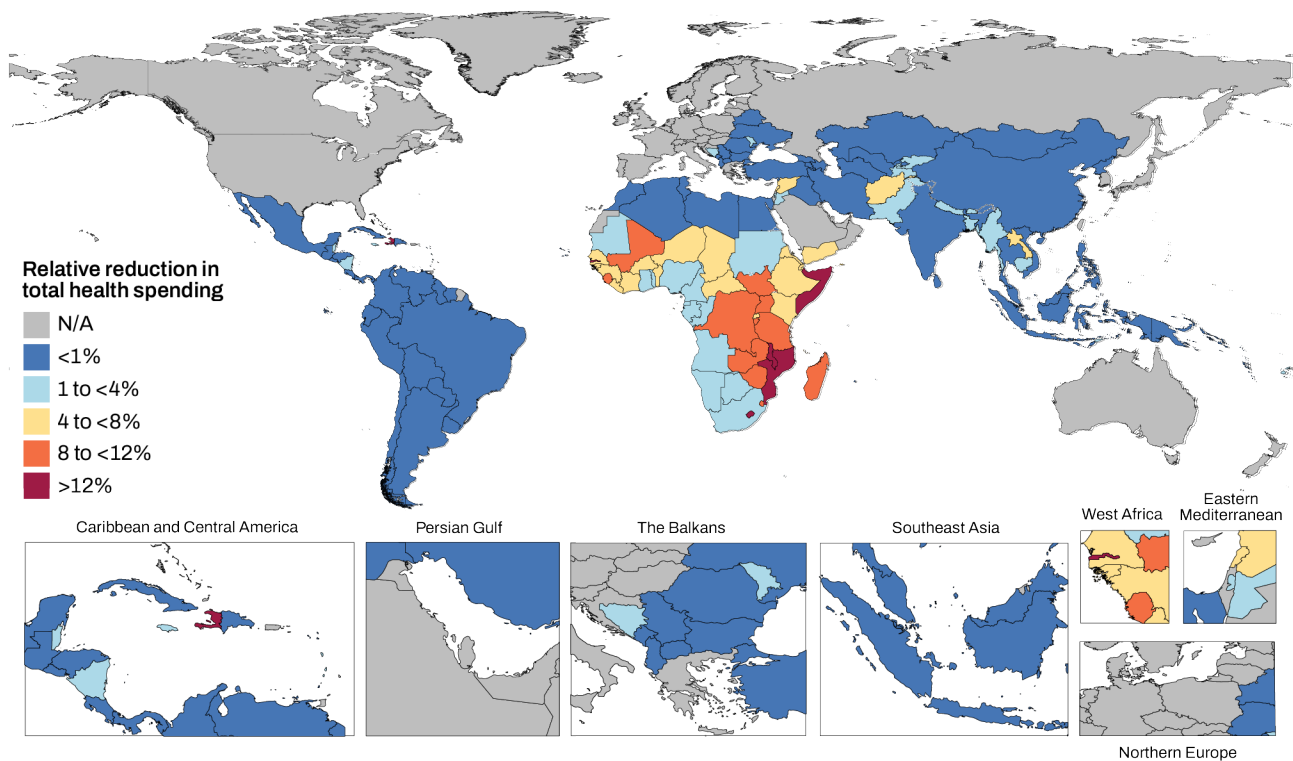
UN Agencies include PAHO, UNFPA, UNICEF, UNAIDS, and UNITAID. Regional development banks include African Development Bank, Asian Development Bank, and Inter-American Development Bank.

Countries and regions most affected by cuts

As development partners decrease their investments in global health, many news reports have revealed the human face of these cuts.²² IHME predicts that countries in sub-Saharan Africa might see the greatest decreases in their total health spending between 2024 and 2025. It is estimated that Malawi will lose the largest amount – 17% in 2025 – while Mozambique, Lesotho, the Gambia, and the Marshall Islands will lose 14–15% of their total health spending. Other countries that may face substantial reductions include the Marshall Islands in Oceania along with Haiti in the Caribbean.

These potential spending reductions could make it harder for countries to achieve the Sustainable Development Goals (SDGs). Already, before

Figure 10: Preliminary estimates of relative reduction in total health spending due to reduced development assistance for health, 2024–2025



The relative reduction in total health spending due to reduction in development assistance for health is calculated by dividing the change in each country's DAH from 2024 to 2025 by the country's total health spending in 2022, which is the last year of retrospective total spending estimates.

Estimates differ from Lancet estimates published by Apeagyei et al. due to differences in the time period shown and the fact that IHME updated its database to include the pledges Gavi received on June 25, 2025.

development partners cut their DAH, progress on achieving these goals was a challenge. For one focus area of the SDGs, the global nutrition targets – which aim to increase rates of exclusive breastfeeding; decrease low birth weight, stunting, wasting, and overweight among children; and reduce anemia among women of reproductive age – IHME estimated that 89 countries would not reach any of these goals.²³

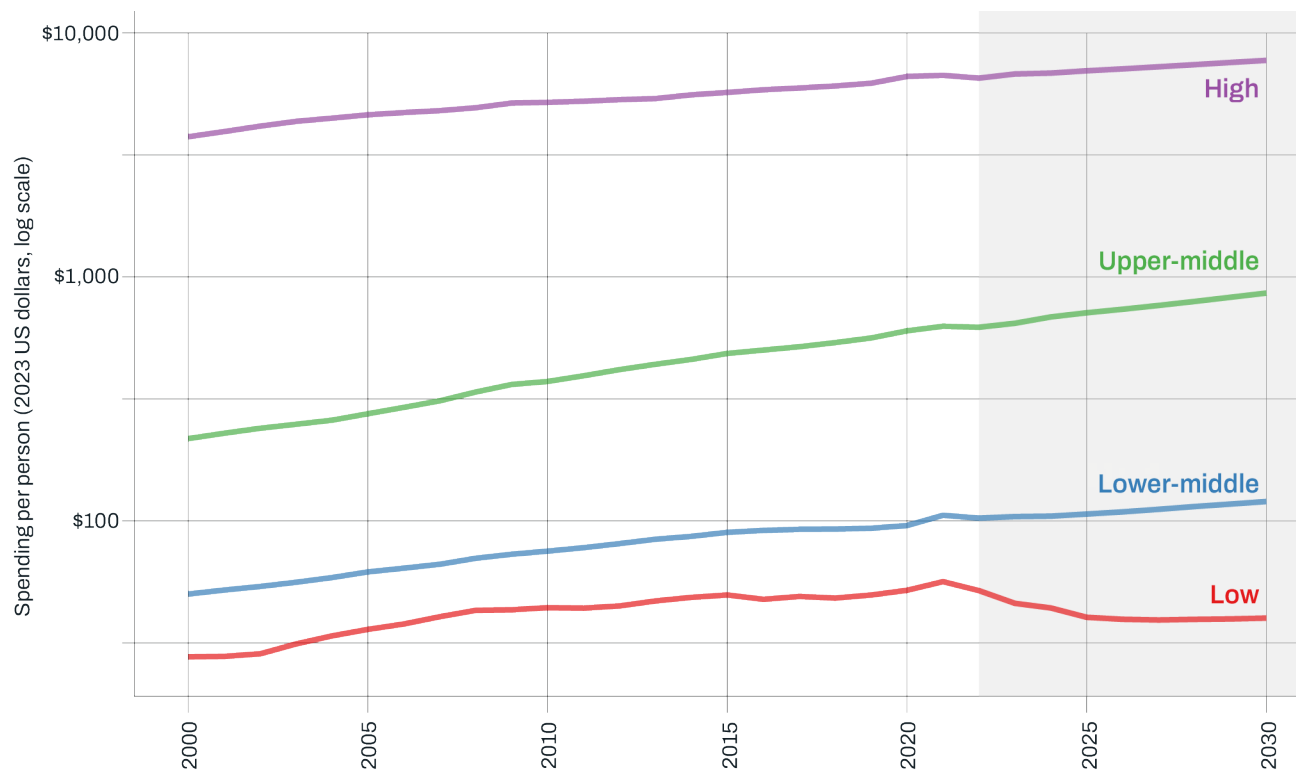
Can governments in low- and middle-income countries fill the DAH gaps?

As governments in high-income countries reduce their development assistance for health, governments in low- and middle-income countries face calls to increase their health spending. To address the financing gaps, Nigeria has pledged to invest an additional \$200 million into its health budget.²⁴ However, IHME's findings suggest that countries are unlikely to be able to make up for the cuts in DAH. IHME forecasts that health spending in areas with the fewest resources – including countries experiencing conflict – will remain extremely low, meaning that people could be pushed into poverty to pay for health care, or forego care. In 2025, for example, the average low-income country spent a total of \$40.29 per person on health, which includes funding from countries' governments, development partners, and families' spending from their own pockets. In five years' time, forecasts indicate that this situation will be largely unchanged, with \$40.00 per person spent on health in low-income countries.

The amount that low- and middle-income countries spend on health pales in comparison to higher-income countries. In 2025, health spending in high-income countries was 299 times greater than in low-income countries. IHME predicts that this gap will widen in the future. The countries that are experiencing the greatest cuts are also the countries that are least capable of filling these gaps in funding.

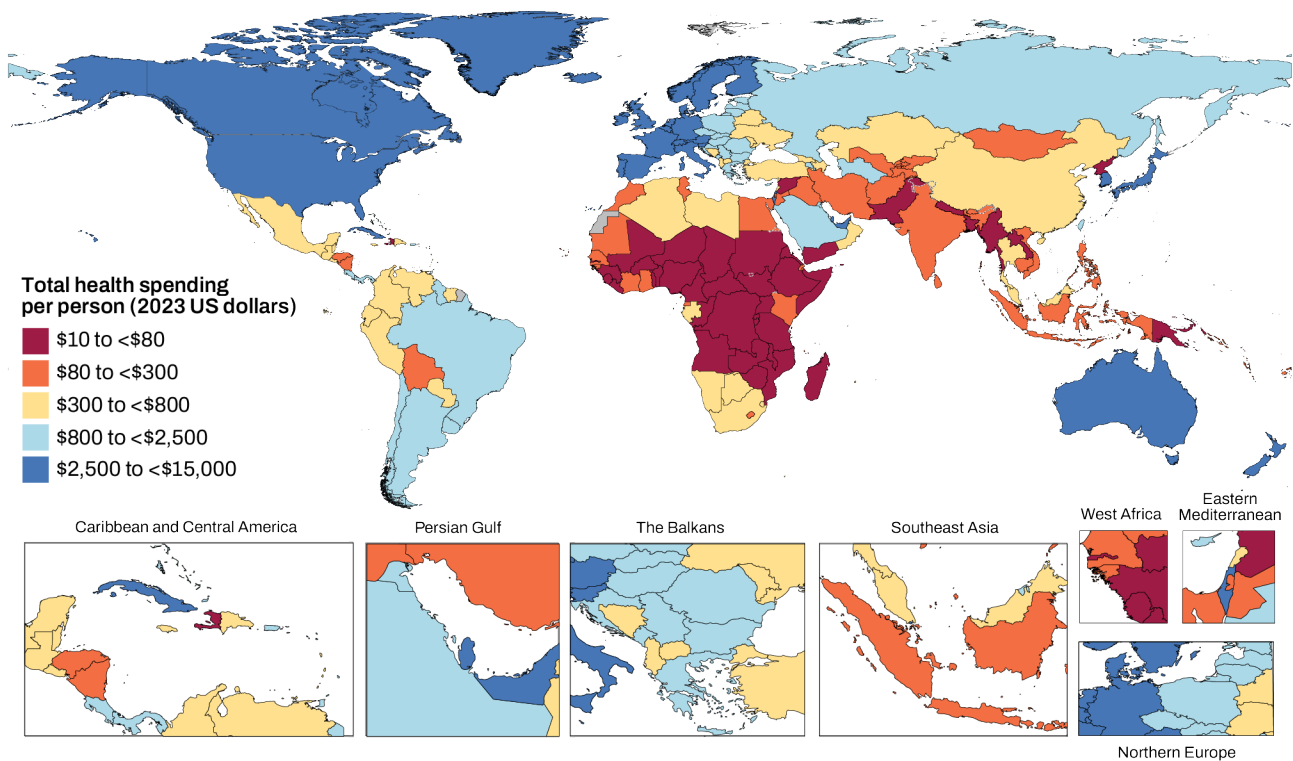
If countries are not able to fill the financing gaps with their own funds, then they will be forced to cut services or improve efficiency. Other IHME research shows that many countries, including low- and high-income countries, could improve their health by boosting efficiency, but these steps are difficult and lack a clear path.²⁵ In one early example, Zambia is digitizing its health system to serve more people and improve their access to medicine, especially in rural areas.²⁶

Figure 11: Total health spending per person by World Bank income group, 2000–2030



Total health spending per person is measured in 2023 real US dollars, with 2023–2030 estimates being forecasted based on retrospective estimates ending in 2022. The y-axis reports values on a log base-10 scale due to the dramatic differences in income group spending.

Figure 12: Forecasted total health spending per person, 2025



Total health spending per person is measured in 2023 real US dollars, with 2025 estimates being forecasted based on retrospective estimates ending in 2022.

Conclusion

As funding for global health drops to levels last seen in 2009, mitigating the impact of the rapid declines in DAH hinges on low- and middle-income countries' ability to mobilize their own domestic resources for health, which varies widely from country to country, or to enhance health system efficiency.

After achieving unprecedented success in improving health worldwide over the last 20 years, this progress is at risk as countries such as the US, the UK, France, and Germany have reduced their DAH. At the same time, while many high-income countries are increasingly turning their focus inward, the global health landscape is changing. The Africa Centres for Disease Control (Africa CDC), which helped countries procure lifesaving supplies during the COVID-19 pandemic, is rallying countries in the region to increase their health budgets.²⁷ However, IHME's findings suggest there is little room for countries with the fewest resources to increase their spending. Africa CDC is also working to raise funds from private partners and airline taxes to protect the continent's health. The organization plans to use these funds to combat outbreaks of infectious diseases such as Ebola.

The health implications of the sharp drop in DAH between 2024 and 2025 may be profound. It is likely that people are losing access to lifesaving health care services. The rapid improvements in global health seen over the past few decades are now in danger of slowing or reversing. The responses from recipient governments and other global stakeholders will likely be consequential in determining the trends we observe in health outcomes in the near future.

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Methods appendix

Overview

The *Financing Global Health 2025* report provides estimates derived from the most accurate and current data available as of June 2025. Using a wide range of sources, including spending accounts, budgets, and other financial estimates, we applied statistical models and accounting techniques to generate our findings. This section offers a concise overview of our methodology. For detailed information on the input data and methodology, please refer to our online Methods Annex, available at <https://rebrand.ly/FGH-annex>.

Development assistance for health

IHME gathered financial data from the sources and organizations mentioned in this report. The objective was to monitor disbursements intended to support or enhance health in low- and middle-income countries over the period from 1990 to 2025. Along with using data from global databases like the OECD's Creditor Reporting System, we collected and standardized information on commitments and disbursements from development project records, annual budgets, financial statements, and revenue reports. These data were sourced from a wide range of development organizations, including multilateral and bilateral aid agencies, public-private partnerships, NGOs, and private foundations. In addition, direct communication with several disbursing agencies helped improve the understanding of their data and enabled access to more detailed, reliable, or timely information. However, some organizations could not provide disbursement figures for the previous year due to lengthy accounting processes. As a result, we relied on budgets, revenues, commitments, appropriations, and macroeconomic data to estimate disbursements for agencies lacking current spending data.

Global health agencies often transfer funds among themselves, which can result in double-counting when both the originating agency and the recipient agency report the same transactions. Including disbursements from both parties would inflate the total figures. To prevent this, we analyzed revenue data to identify the original source of funds and excluded amounts transferred between development agencies prior to final disbursement. In our framework, the source of funds refers to their point of origin, while the channel represents the final disbursing agency we track distributing those resources. Since data sources vary in how they categorize and detail the focus areas targeted by their disbursements, we employed project-specific sector and theme codes along with keyword searches of project titles and descriptions to classify funding. Furthermore, all DAH from the Joint United Nations Programme on HIV/AIDS (UNAIDS) was classified as funding for HIV/AIDS and tuberculosis. Funding from UNICEF was categorized as DAH supporting reproductive, maternal, newborn, and child health, HIV/AIDS, and Ebola. For projects addressing

multiple health focus areas, the funding was allocated proportionally using weights determined by the frequency of keywords linked to each specific focus area. DAH estimates were reported in 2023 US dollars.

Estimating 2025 development assistance for health

Given the changes to the global health financing landscape in 2025 stemming from announcements of cuts from several donors, we set out to estimate 2025 DAH based on information gathered about these cuts to global health funding and development assistance. We generally relied on public statements and news articles from and about the country governments that provide DAH, such as statements from the US government about downsizing USAID, US proposals for 2025 budget rescissions and the 2026 Congressional budget justification, or the United Kingdom FCDO's proposed development assistance budget. These sources provided information about the relative sizes of funding cuts and funding increases to development assistance and/or global health programs. Using this information, we determined how expected levels of 2025 DAH might compare to 2024 levels and adjusted our 2024 estimates accordingly to produce the 2025 estimates. We often utilized cuts in total development assistance and assumed that they applied equivalently to development assistance for health. Additionally, for funding sources where we found no or inconclusive information regarding 2025 development assistance, we held DAH constant from 2024 to 2025.

Domestic health spending and total health spending

We gathered and refined health spending data from the World Health Organization Global Health Expenditure Database to estimate total health spending and health spending by source. The data we extracted included transfers from government domestic revenue allocated for health, social insurance contributions, mandatory prepayments, voluntary prepayments, and other domestic revenue from households, corporations, and nonprofit institutions serving households. Using this approach, we obtained spending estimates spanning the years 2000 to 2022, presented in current local currency and converted into 2023 US dollars. Next, we applied a spatiotemporal Gaussian process regression model (ST-GPR) to estimate health spending across all years, countries, and spending categories. This model also enabled us to produce 500 draws for each data point, capturing the uncertainty inherent in the estimates.

We gave priority to data from the Global Health Expenditure Database with the most reliable sources and thorough documentation for our ST-GPR modeling. To achieve this, we utilized a natural language processing model to assess and assign weights to each data point based on metadata detailing the source and estimation methods. The weights were determined by factors such as the completeness of metadata, the presence of documented source information, and the clarity of estimation methods. Although all available data were incorporated into the ST-GPR model, data from the most credible sources with the most comprehensive documentation had the greatest influence on the model. Finally, we combined DAH, government health spending, prepaid private

health spending, and out-of-pocket health spending to calculate total health expenditures in 2023 US dollars.

Forecasting development assistance for health provided through 2050

To project development assistance for health donated in the long term, we used information on donors' targets for official development assistance (ODA) funding. For donors that use ODA per gross national income (GNI) targets to determine their ODA funding amounts, we collected information on their funding targets from government budgets and press releases. We projected GNI as a function of gross domestic product (GDP) and multiplied by these targeted ratios of ODA per GNI for each donor country, to obtain ODA forecasts. We then used data from the OECD CRS database on each donor's DAH per ODA ratio and multiplied that by the ODA forecasts to obtain total DAH forecasts for each donor. For donors without ODA per GNI targets, we held constant DAH based on 2025 levels. For the Gates Foundation, we assumed constant DAH funding until 2045, when the Foundation will close. For additional donor sources such as other OECD DAC countries, debt repayments, other public donors, private donors, and unallocable donors, we created projections using a linear model based on the historical time trend of DAH donated. Once we created projections for all donors, we used retrospective estimates of DAH flows to calculate the fraction of DAH provided by donors and channels received by different countries. Using this approach, we generated short-term forecasts of DAH by recipient country through 2030.

Future health spending

To project future health spending, we forecasted several key indicators through 2050, including GDP, overall government spending across all sectors, debt as a percentage of general government expenditure, total DAH provided and received as a share of total DAH contributions, as well as government, out-of-pocket, and prepaid private health spending. We used ensemble models to predict these indicators, incorporating a variety of submodels with diverse predictors and modeling approaches. After conducting out-of-sample tests, we identified the best-performing subset of submodels and employed them to generate forecasts, producing 500 draws for each indicator to account for uncertainty.



IHME



UNIVERSITY of WASHINGTON

INSTITUTE FOR HEALTH METRICS AND EVALUATION

Hans Rosling Center for Population Health

3980 15th Ave NE, Seattle WA 98195

UW Campus Box #351615

Phone: +1 (206) 897-2800

Fax: +1 (206) 897-2899

Email: engage@healthdata.org

www.healthdata.org