Health is the most prominent sector in the MDGs, with three goals dedicated to it, but on which progress has varied. MDG target 4.A aimed to reduce by two-thirds the under-five mortality rate, but only a 50% reduction has been achieved. MDG target 5.A (to reduce maternal mortality by three-quarters) and target 5.B (universal access to reproductive healthcare) will be missed by wide margins. Efforts to combat key diseases (target 6) are mainly paying off, with a 25% fall in deaths from malaria and lower rates of new HIV infections, but many people still do not have access to anti-retroviral treatment.\textsuperscript{38}

Are countries meeting the health spending targets?

Ensuring that healthcare is free and universally provided takes significant government spending. Over a decade ago, two clear targets were established. In 2002, at a Special Summit in Abuja, Nigeria, African Heads of State committed themselves to allocate 15% of government expenditure to health. Globally, the WHO Commission on Macroeconomics and Health in 2001 concluded that a minimum of US$34 per capita was required to be spent on health to reach the health-related MDGs.\textsuperscript{39} More recently, the Taskforce on Innovative International Financing forecast that, by 2015, US$60 per capita was needed to strengthen health systems and provide essential services in 49 low-income countries (LICs).\textsuperscript{40}

In 2014, GSW data show that no sub-Saharan African country met the 15% Abuja target.\textsuperscript{41} Malawi met it in 2011, and was the highest-spending country in 2008–14 (averaging 13%). The only other country to meet the target in the GSW database was Togo in 2008. Ten countries exceeded 10% of allocations in either 2013 or 2014 – Burkina Faso, Burundi, DRC, Ghana, Lesotho, Liberia, Malawi, Swaziland, Mali and Zambia. Senegal was the lowest-spending African country in 2014, spending below 5% – well below the Abuja target.\textsuperscript{42} Among non-African countries, Kiribati met 15% in 2010, and El Salvador and Nicaragua are at 17%.

In relation to the target of US$60 per capita, 23 countries of 59 with data available planned to spend above US$60 in 2014. However, these included only four LICs (for whom the target was set), and average LIC per capita spending is below US$20, with the lowest spenders being Haiti (US$6), Madagascar (US$4) and Zimbabwe (under US$1). Unsurprisingly, lower-middle-income countries (LMICs) and middle-income countries (MICs) tend to spend much more per capita, with 13 spending over US$100. Some MICs are spending very low amounts, such as India at a shocking US$18 per person. By far the highest-spending country per capita in the GSW database is Samoa, at $315 per capita; since 2008, spending on health has doubled as a percentage of total spending, although this appears to be temporary spike, possibly as a result of post-cyclone reconstruction. Overall, most countries are spending much less than is needed.
What are the recent trends in health spending?

Overall, the latest year’s GSW data indicate virtually no rise in health spending as a percentage of GDP since 2012, with spending standing at 2.7% of GDP, the same as the 2009 level cited in the GSW 2013 report. However, the average proportion of total government spending has fallen since 2012, from 9% to 8.6%. During 2012–14, only half the countries increased health spending compared with total spending, as did 52% as a percentage of GDP. These trends are very worrying, given the major shortfalls in meeting the health MDGs.
Health SDGs require a trebling of spending and careful tracking

The draft SDGs are much more ambitious than the MDGs on health: they target universal access to healthcare (UHC) and focus on accelerating reductions in maternal and child mortality and increasing access to sexual and reproductive health services. The consensus in the international health community is that UHC-related spending needs to be predominately public. Ensuring that healthcare is free at the point of delivery will also be critical to achieving equity (as will be shown in the next section). This will require a significant scale-up of spending – which makes the context of current stagnant spending very worrying.

In particular, this will require a vast scaling up of public spending. The Lancet Commission on Global Health 2035 has suggested that LICs and LMICs would need to spend US$51 billion more a year from 2015, rising to $80 billion in 2035, saving an additional 10 million lives.

One further major issue will need to be resolved in monitoring spending on the SDGs: the degree and nature of disaggregation. As research carried out by GSW has found, data in the health sector are very difficult to disaggregate. Whether considering beneficiaries for maternal and child health, spending on particular diseases or spending by objective such as sexual and reproductive health, it is fiendishly difficult to disentangle spending by intended outcome or with a focus on equity. Though overall health spending will need to be tracked to reach UHC, only more detailed data can assess whether governments are adequately tackling the main barriers to UHC and achieving higher life expectancy, as well as targeting those most in need.

MDG target 1.A is to halve the proportion of people whose income is less than US$1.25 a day. This target was met in 2010, lifting half a billion people out of poverty in the process. However, concerns remain about the fact that many countries, especially in Africa, did not meet the target.