

PART ONE:

DEVELOPMENT ASSISTANCE FOR HEALTH

CHAPTER 1:

TRACKING DEVELOPMENT ASSISTANCE FOR HEALTH

Global health lacks a single data repository that would allow policymakers and researchers to have an accurate picture of donations, spending, and the complex relationships between them. Figure 1 shows a simplified representation of the three basic categories of actors in the funding of development assistance for health (DAH) – funding sources, channels of assistance, and implementing institutions – as well as how resources flow through these actors. The global health channels receive funds from sources, which can be broadly categorized as national treasuries in donor countries, charitable donations from private philanthropists,

corporate donations, and debt repayments on previous development assistance loans. The channels transfer funds to implementing institutions that in turn use them to finance health programs and research. The recipients of global health funds run the gamut from national health ministries and local non-governmental organizations (NGOs) to universities and research institutions in high-income countries that undertake global health research. The channels also spend some funds to implement programs themselves, providing technical assistance, undertaking disease surveillance, or managing loan- and grant-making. In addition, the

FIGURE 1:
Resource flows for DAH



BOX 1:
Summary of Financing Global Health 2009

How we conducted our analysis:

- To provide policymakers and the global health community a better picture of DAH flowing to developing countries, the Institute for Health Metrics and Evaluation and its collaborators tracked, where possible, all health-related contributions made through public and private channels of assistance for each year between 1990 and 2007.
- We reviewed both the income and expenditure data for each of these channels. The data came from annual reports, government documents, audited financial statements, tax forms, and databases provided by public and private donors.
- To make sure we did not double-count the same DAH dollars flowing through several channels, we subtracted transfers between channels tracked by our study from the total DAH envelope. In effect, we counted health aid dollars from the channel closest to the destination of the funds.
- We separated the DAH total into subtotals for sources, channels, and types of funding.
- For a subset of total DAH, we were able to gather project-level or activity-level information. Through this, we analyzed the composition of DAH by health focus area and by recipient country.
- For more information about our methods and key definitions, please visit our online Methods Annex at: http://www.healthmetricsandevaluation.org/publications/financing_global_health_2010_methods_IHME.pdf

Key findings:

- DAH quadrupled from \$5.59 billion in 1990 to \$21.79 billion in 2007 (in 2007 US\$).
- Private citizens, corporations, and foundations have funded an increasingly large share of DAH, making up 27% in 2007.
- DAH growth was driven largely by donations from the US government and US-based private charitable organizations. The US accounted for more than 50% of total DAH in 2007. But in terms of the fraction of national income that becomes health aid, the US trailed Sweden, Luxembourg, Norway, and Ireland.
- In general, poor countries received more money than countries with more resources, but there were anomalies. Sub-Saharan Africa received the highest concentration of funding, but some African countries received less aid than South American countries with lower disease burdens.
- HIV/AIDS received at least 23 cents out of every DAH dollar in 2007. Tuberculosis and malaria received less than one-third of that, even though the combined burden from those diseases was greater than that from HIV/AIDS. About one nickel out of every DAH dollar went to health sector support.

channels give resources to other channels of assistance that in turn use the funds in the ways described above.

In last year's report, we established the foundation for tracking global health resource flows. That work and our key findings are summarized in Box 1. This year, we strengthen our estimates by broadening our base of data sources and improving our analytical methods. The result is a year-by-year estimate of the total volume of DAH from 1990 to 2010. Though data challenges remain, a significant increase in transparency by donor governments in how DAH is being spent also helped us improve our estimates.

In this chapter, we analyze DAH by channel, by funding source, by country of origin, and by type of funding. Our primary sources of data are found in Table 1, including new sources of data added this year. All estimates are presented in 2008 US dollars. Average growth rates are calculated using compound annual growth rates.

By channel of assistance

DAH has steadily increased since 2001, reaching an estimated \$26.87 billion in 2010. For each channel, Figure 2 shows the total financial and in-kind contributions to DAH, after subtracting transfers to other channels.

From 1990 to 2001, DAH increased nearly 86% from \$5.66 billion in 1990 to \$10.51 billion in 2001. Over the next nine years, though, the pace accelerated even more quickly, with DAH growing by 124%.

While DAH has continued to rise, it's clear the growth curve for DAH is starting to flatten. Beginning in 2004, DAH increased annually by more than 8%, reaching a peak of 17% annual growth between 2007 and 2008. Between 2008 and 2009, though, the growth rate slowed dramatically to just 6% before rising slightly to 7% between 2009 and 2010.

In attempting to discern the drivers of this trend, we found that bilateral development agencies and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) had continued channeling significantly higher contributions of DAH from 2008 to 2010, helping to fuel the overall rise in total DAH. DAH disbursed by the GAVI Alliance (GAVI) dropped significantly in 2009, but then doubled in size in 2010. Funding through bilateral agencies, which include the United States Agency for International Development (USAID) and others, grew

from \$9.55 billion in 2008 to \$12.16 billion in 2010, a 27% increase. Other channels – the World Bank, regional development banks, United Nations (UN) agencies, the European Commission (EC), the Bill & Melinda Gates Foundation (BMGF), and other foundations – either saw a slight increase or a slight decrease in funding between 2008 and 2010. US-based NGOs have been hit hard by the economic downturn, and the amount of DAH disbursed by them decreased 24% from 2009 to 2010.

This flattening of the growth curve highlights the shift in the balance of contributions among different channels. Bilateral agencies are now more significant as channels of DAH, making up 45% of all DAH in 2010, up from 30% in 2001. Similarly, GFATM is providing a larger portion of DAH, rising to 11% in 2010 from 1% in 2002. However, the percentage of DAH from UN agencies has declined sharply – 14% in 2010, down from 24% in 2001. And the World Bank's role as a channel for DAH also shrank, representing 5% of all DAH in 2010, down from 17% in 2001.

TABLE 1:
Sources of DAH data

| Source | Data |
|---|---|
| Bilateral agencies in 23 OECD-DAC member countries and the EC | OECD-DAC aggregate database and the Creditor Reporting System (CRS), budget documents, and correspondence |
| UN agencies: WHO, UNICEF, UNFPA, PAHO, and UNAIDS | Financial reports and audited financial statements, annual reports, budget documents, and correspondence |
| World Bank, ADB, AfDB, and IDB | Online project databases and compendium of statistics |
| GAVI | GAVI annual reports, country fact sheets, OECD-CRS, and correspondence |
| GFATM | Online grant database and pledges |
| NGOs registered in the US* | USAID Report of Voluntary Agencies, tax filings, financial statements, RED BOOK Drug Reference, WHO's Model List of Essential Medicines, and correspondence |
| BMGF | Online grant database, tax filings, and correspondence |
| Other private US foundations* | Foundation Center's grants database |

*Non-US private foundations and NGOs were not included due to a lack of comprehensive data.

Note: For more information about these sources, please visit our online Methods Annex at:
http://www.healthmetricsandevaluation.org/publications/financing_global_health_2010_methods_IHME.pdf

By source of funding

Even as the share of health aid provided by various channels of assistance has been shifting, our research has identified another interesting trend: signs that the rate of growth in DAH from some donors began to slow in 2007. Some of the most important sources of DAH funding – including the US and many European governments – continued to significantly increase spending on DAH through 2008. But the growth in DAH from governments such as Canada, Sweden, and Norway either plateaued or slowed. In Figure 3, we detail the percentage share of DAH attributable each year to specific governments and other sources. We also include debt repayments to the International Bank for Reconstruction and Development (IBRD) because, as IBRD receives repayments, they are reinvested as DAH. We were unable to generate preliminary estimates of DAH funding by source separated by recipient country for 2009 and 2010 because of limitations in the available data.

In Figures 2 and 3, two of the same actors appear. BMGF and IBRD are classified as both channels and

sources. Figure 3 includes all their DAH contributed as a channel plus funds transferred to other channels. For example, BMGF acted as both a channel for \$1.43 billion in 2008 and a source for \$1.86 billion that year, meaning that \$426.54 million in BMGF’s spending was channeled through other agents, such as GFATM and GAVI.

Donor governments made up 72% of total DAH flowing to developing countries in 2008 for a total of \$17.12 billion. This is up from \$4.41 billion in 1990, though this was a larger share of DAH that year at 78% of total DAH. The US government has been by far the largest donor of DAH every year since 1990. Cumulatively, the US government contributed \$51.94 billion in DAH between 1990 and 2008.

The United Kingdom (UK) is the second largest government funder of DAH. It showed a significant increase in funding from \$1.58 billion in 2006 to \$2.04 billion in 2007 before dropping its funding to \$1.75 billion in 2008, a decrease of 14%.

FIGURE 2:
DAH by channel of assistance, 1990-2010

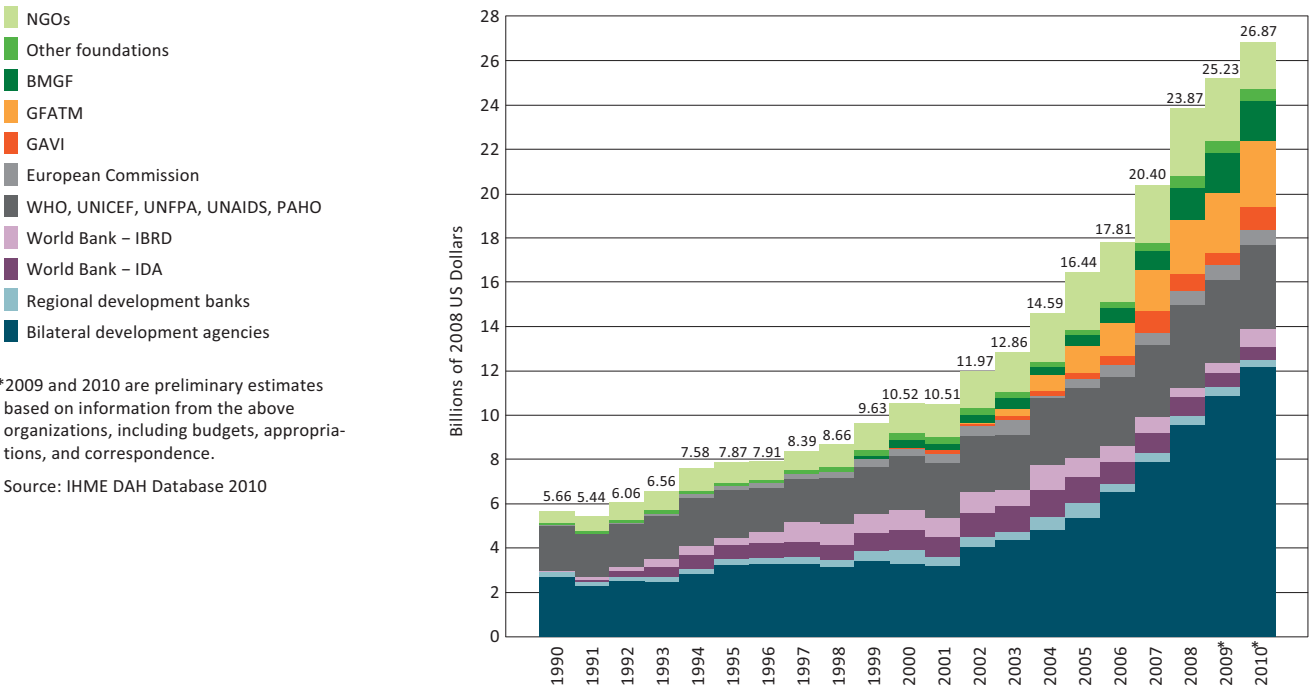


Figure 3 also shows that private sources of funding have been responsible for a growing share of total health assistance, rising from 8% in 1990 to 19% in 2008. These relative shares are smaller than those shown in last year’s report, when we reported private funding sources made up 13% of total health assistance in 1990, rising to 27% in 2007. This is because of a significant change in the way we calculate in-kind donations of medical equipment, pharmaceuticals, and other goods (Box 2).

The corporate donations category includes all in-kind donations from private corporations to US-based NGOs. Generally, corporate donations continued to rise sharply through 2008, from \$187.95 million in 2001 to \$596.21 million in 2008, a 217% increase. All private charitable donations from individuals and US-based foundations besides BMGF as well as cash donations from corporations are included in the “other” category.

In examining the largest private donors, BMGF is the largest single source. It contributed \$1.86 billion in 2008, both directly to developing countries and through other channels, up 292% from \$474.18 million in 2001.

By country of origin

When donor government and private sources within a country are combined, the US proves to have a dominant role in DAH. Most donor countries tend to contribute DAH through their national treasuries, and this is reflected in Figure 3. In contrast, Figure 4 shows all DAH by country of origin. The US consistently is the biggest contributor to DAH, with a large share of DAH coming from private sources. Beginning in 2004, the US government and private donors based in the US increased spending on DAH by double-digit percentages every year, reaching an annual increase of 33% in 2008 for a total of \$11.71 billion that year, equaling about one-half of all DAH. To simplify Figure 4, we have grouped all European countries outside of the UK into one category. However, it is important to note that private sources from countries other than the US were not systematically tracked due to lack of comprehensive data. In future years, we aim to expand our analysis to private funds flowing through European-based NGOs and foundations.

Continental European countries contributed the second largest share of health assistance, followed by the UK, Japan, and Canada.

FIGURE 3:
DAH by source of funding, 1990-2010

Funds from channels for which we were unable to find disaggregated revenue information as well as interagency transfers from non-DAH institutions are included in “unallocable.” “Other” refers to interest income, currency exchange adjustments, and other miscellaneous income.



Source: IHME DAH Database 2010

Notes: 2009 and 2010 are preliminary estimates based on information from channels of assistance, including budgets, appropriations, and correspondence. Data were unavailable to show total DAH by source of funding for 2009 and 2010.

BOX 2:

Improving the valuation of in-kind donations from pharmaceutical companies

Last year, we found that nearly half of all financial contributions to NGOs came in the form of in-kind donations of pharmaceuticals and other medical supplies. In *Financing Global Health 2009*, we presented our estimates of the value of in-kind donations with two caveats.¹ We said that, because of the methods used to assign values to those contributions, the figures could be inflated and worth less in the developing countries to which they were donated than the value claimed by NGOs.

After that report’s publication, we heard from both donors and recipients of in-kind donations who said our reservations about in-kind donations were justified. Through discussions with them, consultations with members of our Advisory Panel, and a thorough review of the literature on this topic, we have improved our analytical methods to refine the picture of in-kind donations.

For *Financing Global Health 2009*, we relied on values reported by NGOs for in-kind donations.¹ The Internal Revenue Service (IRS) requires NGOs to report the “fair market value” of the donations but says, “There is no single formula that always applies when determining the value of property.”¹³ Our review of IRS 990 forms filed by NGOs shows that the method for valuing drugs differs widely among them, but a substantial number use US wholesale prices.

To create a more accurate picture of in-kind donations, we analyzed the relationship between wholesale prices and the US federal upper limit for valuing donations of drugs on WHO’s Model List of Essential Medicines. We based our estimates of in-kind donations on that relationship. For more information about the methodology used to adjust the value of in-kind donations channeled through NGOs, please visit our online Methods Annex at: http://www.healthmetricsandevaluation.org/publications/financing_global_health_2010_methods_IHME.pdf

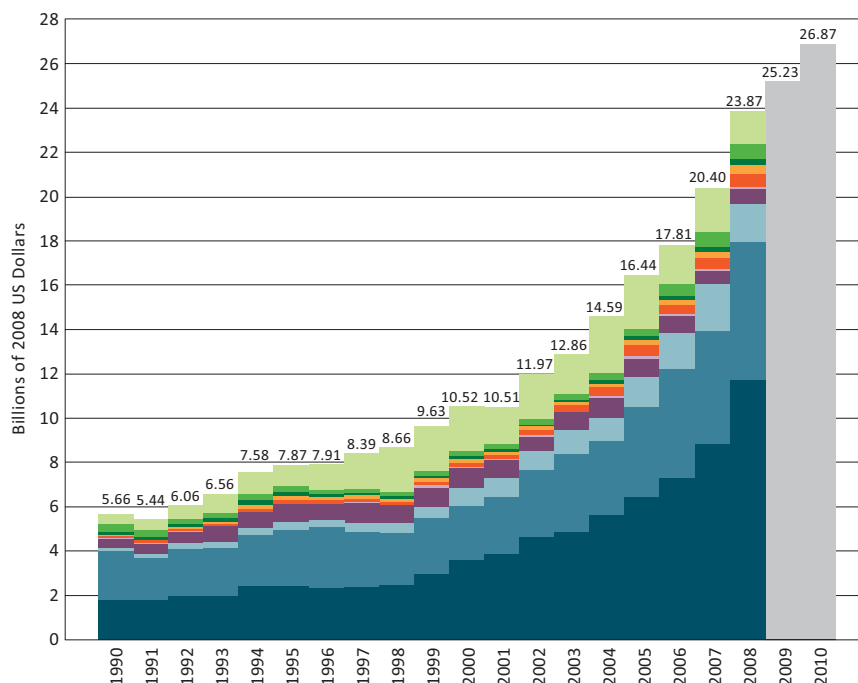
FIGURE 4:
DAH by country of origin, 1990-2010

“Unallocable” includes funds such as interagency transfers from non-DAH institutions, interest income, and miscellaneous income that could not be attributed to countries. Channels for which we had no revenue information are included under “unspecified.”

- Unspecified
- Unallocable by donor
- Other
- Australia and New Zealand
- Canada
- South Korea
- Japan
- United Kingdom
- Europe, excluding UK
- United States
- Preliminary estimates

Source: IHME DAH Database 2010

Notes: 2009 and 2010 are preliminary estimates based on information from channels of assistance, including budgets, appropriations, and correspondence. Data were unavailable to show total DAH by country of origin for 2009 and 2010.



When examined as a fraction of national income, however, the ranking of DAH contributors changes, as seen in Figure 5. Here, we show DAH in 2008 from each of the 23 member countries of the Development Assistance Committee of the Organisation for Economic Co-operation and Development (OECD-DAC) as a percentage of the country's gross domestic product (GDP) that same year, ranked from highest to lowest.

In this context, the US no longer claims the top position but instead ranks fourth. Luxembourg spends the largest share of its GDP on health aid, followed by Norway and Sweden. Portugal, South Korea, and Greece spend the smallest percentages.

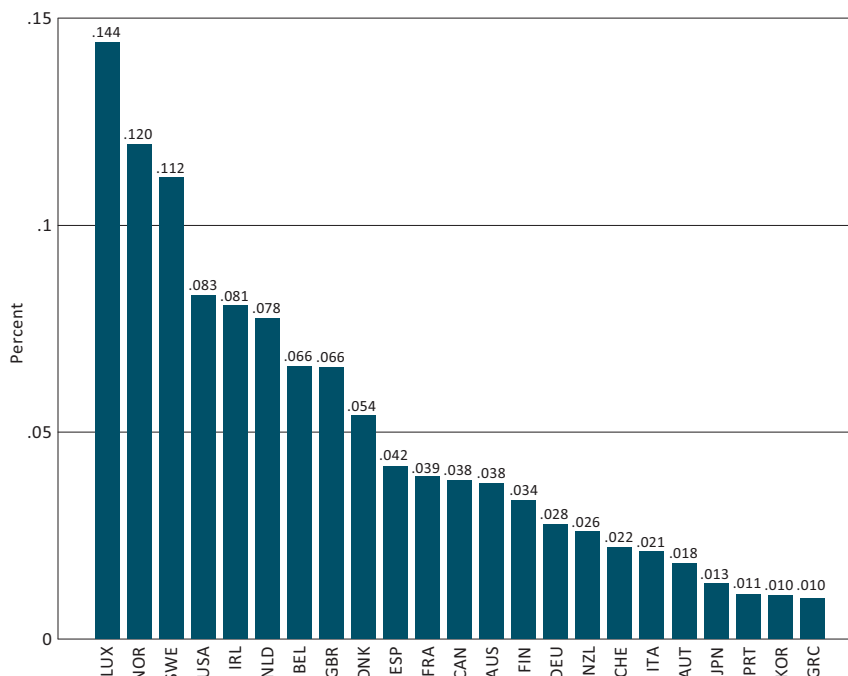
Public sector DAH

The total volume of DAH from governments, which we have grouped together as public sector DAH, grew from \$4.19 billion in 1990 to \$16.78 billion in 2008. Figure 6 shows total public sector DAH at six time periods from 1990 to 2008. The amount of public sector DAH nearly doubled between 1990 and 2002 and then more than doubled between 2002 and 2008.

The figure also shows the composition of all public sector DAH that flowed through each channel of assistance tracked in the study. What can be seen clearly is how public funds have flowed through the traditional channels for DAH – the UN agencies and the International Development Association (IDA) – at a fairly consistent rate for the past two decades. At the same time, the massive increase in public funding has largely bypassed these traditional channels and has instead flowed to governments through NGOs, GAVI, GFATM, and bilateral mechanisms. Public funding of NGOs, public-private partnerships, and other private groups grew from \$74.54 million in 1990 to \$5.82 billion in 2008. Government-to-government funding through bilateral agencies grew from \$139.14 million in 1990 to \$4.82 billion in 2008. Funding for GFATM in 2008 was \$1.91 billion. This means that while government-to-government contributions once dominated DAH, most DAH is now channeled to non-governmental global health entities. It is important to note that donors reported channels of assistance less completely in the past, preventing us from fully understanding how these trends have changed over time.

FIGURE 5:
DAH as a percentage of national income, 2008

- AUS = Australia
- AUT = Austria
- BEL = Belgium
- CAN = Canada
- CHE = Switzerland
- DEU = Germany
- DNK = Denmark
- ESP = Spain
- FIN = Finland
- FRA = France
- GBR = United Kingdom
- GRC = Greece
- IRL = Ireland
- ITA = Italy
- JPN = Japan
- KOR = South Korea
- LUX = Luxembourg
- NLD = the Netherlands
- NOR = Norway
- NZL = New Zealand
- PRT = Portugal
- SWE = Sweden
- USA = United States



Sources: IHME DAH Database 2010 and World Bank World Development Indicators

In Figure 6, we also see the significant improvements in transparency among public sector donors. Bilateral aid for which the OECD-DAC's data did not include any information about the channel of delivery is marked as "unspecified." In 1990, the amount of funding that was listed as unspecified totaled \$2.73 billion, or 65% of all funding. In 2008, that fraction dwindled to \$179.38 million, or 1% of all public sector DAH.

In Figure 7, we further analyze public sector DAH to show the composition of public funds by channel for each donor country in 2008. Countries are ordered from left to right based on what percentage of their DAH is channeled through bilateral mechanisms to governments in developing countries.

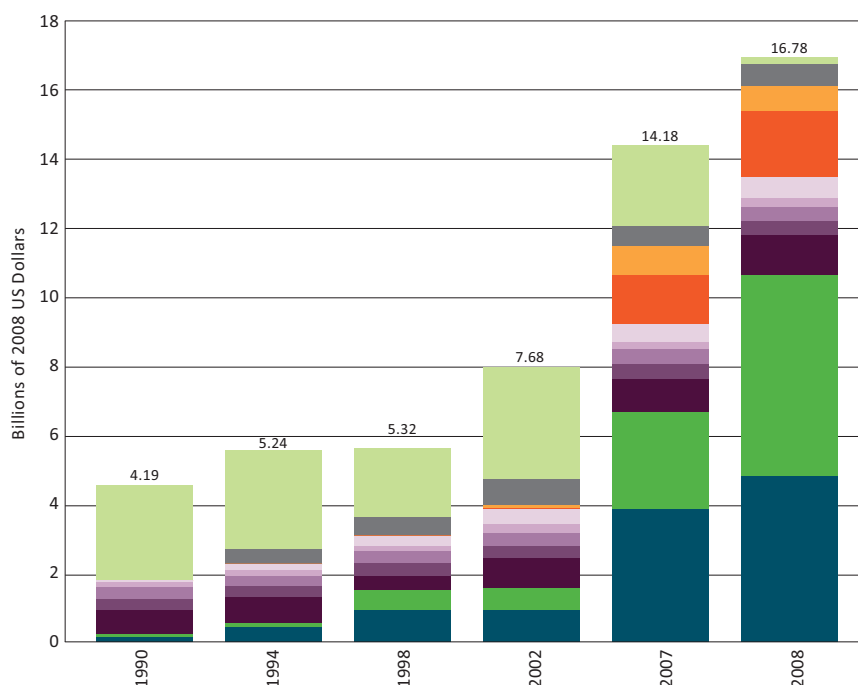
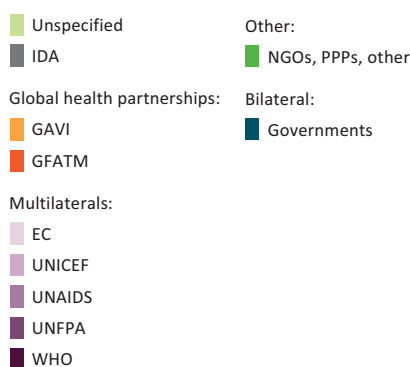
South Korea ranks highest, with 55% of its DAH going through bilateral mechanisms to governments in developing countries, and Canada ranks lowest at 5%. The US directs 33% of its DAH through bilateral mechanisms to governments, while the largest share, 51%, goes to NGOs and other organizations. Australia, New Zealand, and Canada also are notable for channeling 40% or more of their DAH to NGOs, public-private partnerships, and other organizations.

Some countries, including Finland, Denmark, and Greece, mainly channel their DAH through multilateral mechanisms, including the UN agencies, the EC, and the World Bank. In terms of commitments to GFATM, Germany, France, Italy, Spain, and Japan stand out for committing more than 20% of their DAH to that channel.

As will be seen in Chapter 2, country aid decisions are not always based on the greatest need and can be influenced by historic or economic ties or other factors. When channeling money through bilateral mechanisms to recipient governments, donor governments may attach conditions in order to have more control over where their DAH goes. These arrangements have been criticized by some as allowing donor governments to use aid as a way to promote their own priorities and agendas.^{14,15} Multilateral arrangements have critics, too, who say that there is not enough accountability in these arrangements and that UN agencies and the World Bank can put too many restrictions on recipient countries, forcing them to shift their priorities for the sake of receiving aid.¹⁶

FIGURE 6:
Public sector DAH received by channels of assistance, 1990, 1994, 1998, 2002, 2007, and 2008

Bilateral assistance from the 23 member countries of the OECD-DAC are further disaggregated into aid going to recipient governments and flows to NGOs, public-private partnerships (PPPs) excluding GAVI and GFATM, and other miscellaneous channels. Disbursements for which the channel was not specified in OECD-DAC's database are labeled "unspecified."



Source: IHME DAH Database 2010

Note: See Figure 5 for list of OECD-DAC countries.

In Figure 7, we also document the improvement by donor governments in reporting where their money is going. In 2007, 31% of DAH from the US was unspecified, meaning the US did not indicate the channel that would first receive its aid. Since then, the US has changed the way it reports its funding to OECD-DAC. As of 2008, 100% of US funding could be tracked to a specific channel, and Japan, France, and Italy also reported more information about the recipients of their aid. No country has an unspecified amount that is more than 10% of its total DAH funding, although Canada, Japan, and France still have room to improve.

Private philanthropy and DAH

Given the nature of government spending, which often entails a lengthy budgeting process and multi-year funding commitments, it is perhaps not surprising that the global economic downturn has not resulted in an immediate drop in public sector DAH. Within the sphere of private spending on DAH, though, we can see the clearest signs of a contraction in DAH funding.

We have attempted to capture the widest possible array of sources for private contributions to DAH. Our

research was hindered by the lack of an integrated database for tracking private philanthropy. Thus, we have had to estimate based only on contributions from NGOs registered with USAID and private US-based foundations. This includes many of the largest NGOs working worldwide, given that a large number of NGOs headquartered outside of the US maintain US offices and report their spending to USAID.

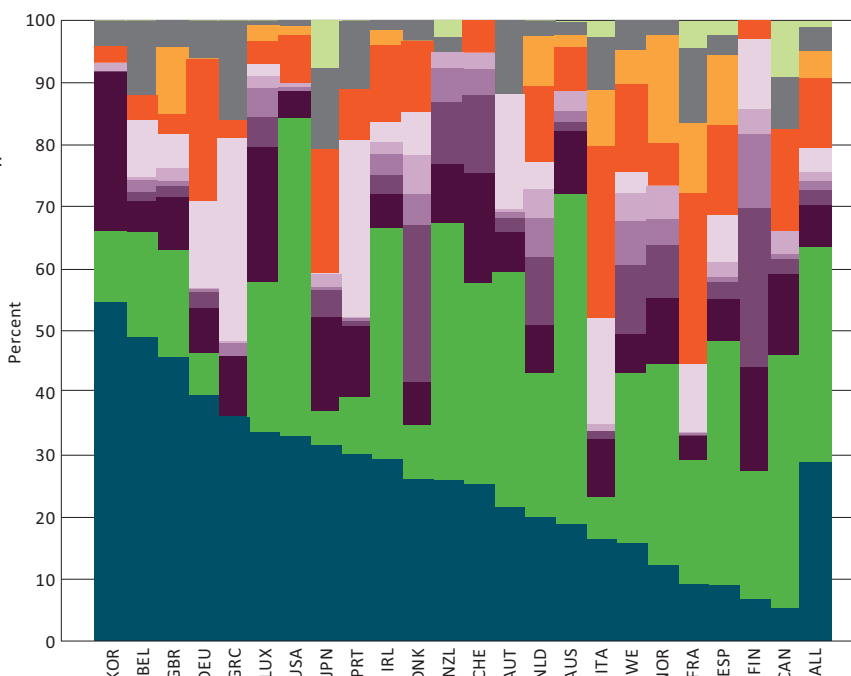
As for organizations not included in this report, our review of available financial data leads us to conclude that they comprise a small fraction of total DAH funding. As seen in Table 2, the most recent USAID Report of Voluntary Agencies¹⁷ lists fewer than 70 NGOs based outside the US that are engaged in overseas relief and development. Of those, we were able to find health expenditure data for 11 in 2008. That spending amounted to \$497.27 million in 2008, equal to 2% of all DAH in 2008.

What follows is our analysis of the role of US-based NGOs and private foundations in channeling DAH to developing countries.

FIGURE 7:
Public sector DAH by donor country received by channels of assistance, 2008

The composition of DAH from the 23 member countries of the OECD-DAC is shown.

- ALL = All-country average
- AUS = Australia
- AUT = Austria
- BEL = Belgium
- CAN = Canada
- CHE = Switzerland
- DEU = Germany
- DNK = Denmark
- ESP = Spain
- FIN = Finland
- FRA = France
- GBR = United Kingdom
- GRC = Greece
- IRL = Ireland
- ITA = Italy
- JPN = Japan
- KOR = South Korea
- LUX = Luxembourg
- NLD = the Netherlands
- NOR = Norway
- NZL = New Zealand
- PRT = Portugal
- SWE = Sweden
- USA = United States
- Unspecified
- IDA
- Global health partnerships:
 - GAVI
 - GFATM
- Multilaterals:
 - EC
 - UNICEF
 - UNAIDS
 - UNFPA
 - WHO
- Other:
 - NGOs, PPPs, other
- Bilateral:
 - Governments



Source: IHME DAH Database 2010

Note: Unspecified indicates donor country did not report the specific channel that would first receive its DAH.

Non-governmental organizations

US public funding of NGOs continued to grow, albeit weakly, through 2010, according to our preliminary estimates. Private funding, which comprises the largest share of DAH channeled through NGOs, spiked in 2008 and then began to fall, driving an overall 30% decrease in DAH funding through NGOs to a low of \$2.16 billion. We arrived at these estimates by analyzing data from tax filings for NGOs and the USAID Report of Voluntary Agencies. For more information about how we performed this analysis, please visit our online Methods Annex at:

http://www.healthmetricsandevaluation.org/publications/financing_global_health_2010_methods_IHME.pdf

Figure 2 showed the portion of DAH directed to NGOs. In Figure 8, we analyze that share of DAH by funding source and, in doing so, show a clear downward trend from all sources except US public funding.

Funding from the US government to NGOs remained fairly constant between 2004 and 2007 before growing 16% to \$955.10 million in 2008. Since then, it has grown

only 1% to \$969.16 million in 2010. This still represents a 323% increase since 1990. Public funding from sources outside the US, including funding to US-based NGOs from other national treasuries, dropped 61% between 2009 and 2010 to \$135.22 million, its lowest point since 2000.

Private donors, including individuals, foundations, and corporations, gave \$1.16 billion in cash to NGOs in 2008. Corporations also donated \$596.21 million in pharmaceuticals, medical equipment, and other in-kind contributions. By 2010, those numbers had dropped 33% and 59%, respectively.

Our recalculation of the value of in-kind donations has greatly changed the ranking of US-based NGOs with the most overseas health expenditures. As seen in Table 3, Population Services International now has the highest total overseas health expenditure of \$1.40 billion. The organization receives significant funding from the US government through the US President's Emergency Plan for AIDS Relief (PEPFAR) and very little funding from private sources.¹⁸ The opposite is true of

TABLE 2:
Summary of health spending by non-US NGOs, 1998-2008

| Year | Number of non-US NGOs in USAID report | Number of non-US NGOs for which we found health expenditure data | Health expenditures by largest non-US NGOs* (in millions US\$, 2008) |
|---------------|---------------------------------------|--|--|
| Prior to 1998 | 0 | – | – |
| 1998 | 44 | 3 | – |
| 1999 | 0 | – | – |
| 2000 | 50 | 6 | 148.56 |
| 2001 | 51 | 7 | 152.13 |
| 2002 | 58 | 7 | 149.58 |
| 2003 | 54 | 7 | 203.11 |
| 2004 | 55 | 9 | 209.86 |
| 2005 | 59 | 9 | 226.61 |
| 2006 | 67 | 8 | 236.42 |
| 2007 | 68 | 10 | 417.20 |
| 2008 | – | 11 | 497.27 |

*Ranking determined by amount of overseas expenditure.

Notes: Data reflect non-US-based NGOs registered with USAID. USAID data for 2008 were not available at the time of the analysis, so we used rankings from 2007.

FIGURE 8:
Total overseas health expenditures channeled through US NGOs by funding source, 1990-2010

Total health spending is disaggregated by shares of revenue received from the US government, other public sources of funding, BMGF, financial donations from private contributions, and in-kind donations from private contributions.

- US public
- Other public
- BMGF
- Private financial contributions
- Private in-kind donations

*2008-2010 are based on preliminary estimates.
 Source: IHME DAH Database (NGOs) 2010
 Note: Data reflect US-based NGOs registered with USAID.

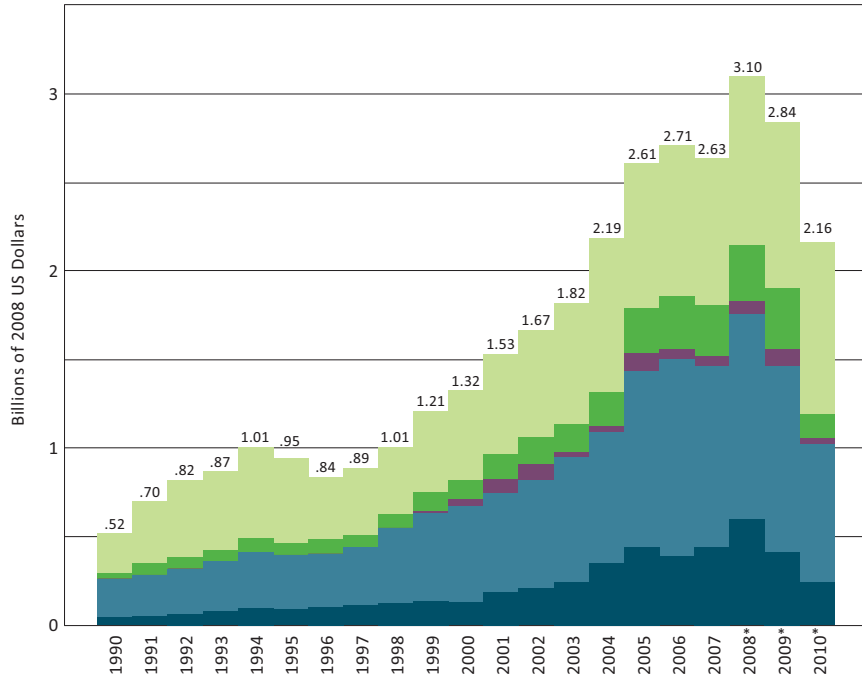


FIGURE 9:
Bill & Melinda Gates Foundation’s global health disbursements and commitments, 1999-2010

The multicolored bars represent disbursements, and the blue bars show commitments. “Universities and research institutions” include universities, NGOs, foundations, and government institutions in low-, middle-, and high-income countries with a research focus. “Country governments” include all nonresearch-oriented government agencies.

- Country governments and IGOs (excluding UN)
- UN
- WB
- GAVI
- GFATM
- PPPs (excluding GAVI and GFATM)
- Universities and research institutions
- NGOs, foundations, and corporations
- Commitments
- Preliminary disbursements

Source: IHME DAH Database (BMGF) 2010
 Notes: 2010 data are based on preliminary estimates obtained from BMGF. Final data were unavailable to show BMGF’s commitments and recipients of disbursements for 2010.

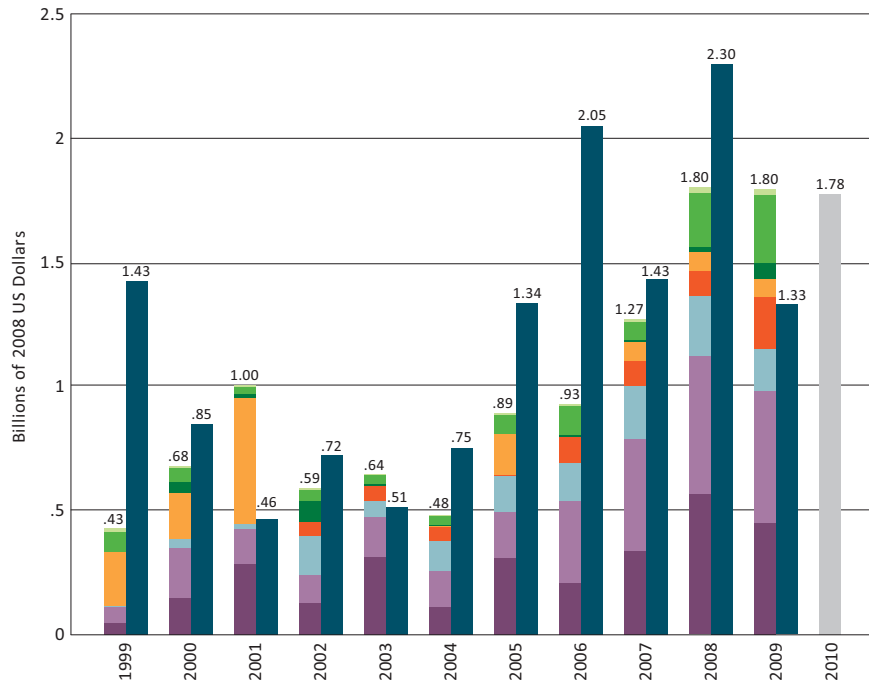


TABLE 3:
US-based NGOs with the highest cumulative overseas health expenditures, 2003-2007

Expenditures shown in millions US\$, 2008.

| Rank | NGO | Overseas health expenditure, adjusted | Overseas health expenditure, unadjusted | Total overseas expenditure, unadjusted | Percent of revenue from private sources | Percent of revenue from in-kind contributions |
|------|--|---------------------------------------|---|--|---|---|
| 1 | Population Services International | 1,397.93 | 1,398.30 | 1,446.23 | 11 | 0 |
| 2 | Food For The Poor | 636.43 | 1,973.02 | 3,838.07 | 93 | 83 |
| 3 | Catholic Relief Services | 616.78 | 625.22 | 2,869.28 | 37 | 2 |
| 4 | World Vision | 589.48 | 771.36 | 3,570.08 | 74 | 29 |
| 5 | Management Sciences for Health | 562.31 | 562.31 | 679.42 | 11 | 0 |
| 6 | United Nations Foundation | 446.14 | 500.61 | 703.54 | 88 | 13 |
| 7 | PATH | 429.73 | 430.55 | 513.31 | 91 | 0 |
| 8 | Pathfinder International | 307.21 | 309.15 | 346.59 | 22 | 1 |
| 9 | MAP International | 287.94 | 1,370.38 | 1,386.15 | 100 | 97 |
| 10 | The Carter Center | 286.53 | 441.71 | 542.96 | 95 | 43 |
| 11 | Project HOPE | 265.97 | 630.13 | 686.36 | 90 | 71 |
| 12 | International Medical Corps | 263.40 | 399.74 | 419.45 | 51 | 42 |
| 13 | Save the Children | 260.39 | 264.13 | 1,375.29 | 50 | 2 |
| 14 | Population Council | 234.10 | 243.83 | 321.88 | 39 | 5 |
| 15 | CARE | 223.36 | 224.75 | 2,824.23 | 26 | 1 |
| 16 | Academy for Educational Development | 215.94 | 218.55 | 1,086.21 | 15 | 1 |
| 17 | Elizabeth Glaser Pediatric AIDS Foundation | 205.64 | 206.61 | 235.66 | 23 | 1 |
| 18 | Catholic Medical Mission Board | 201.58 | 839.62 | 883.33 | 99 | 93 |
| 19 | Brother's Brother Foundation | 184.66 | 966.13 | 1,314.56 | 100 | 99 |
| 20 | Feed the Children | 175.73 | 546.62 | 1,924.15 | 97 | 83 |

Source: IHME DAH Database (NGOs) 2010

Notes: Overseas health expenditure for 2008-2010 is not included because of data limitations. Data reflect NGOs registered with USAID. Adjusted overseas health expenditure reflects deflated overseas health expenditure from private in-kind donations plus unadjusted overseas health expenditure from all other revenue sources (private financial contributions, BMGF, US public, and other public).

the organization with the second highest amount of overseas health expenditure, Food For The Poor, which receives 93% of its funding from private sources.

The organizations on the list span a range of missions, including narrowly defined goals of finding better HIV/AIDS treatments and broad missions of raising the standard of living for children worldwide. Faith-based organizations are difficult to track because they are not obligated to report information on their finances to the Internal Revenue Service. Our analysis captures a portion of these organizations. Six NGOs on the list have a religious affiliation, making up a combined 32% of all cumulative overseas health spending listed in Table 3 from 2003 to 2007.

Foundations

Funding channeled through foundations also slowed greatly over the past two years.

Using a grants database from the New York-based Foundation Center,²⁰ which compiles funding statistics from all major philanthropic foundations registered in the US, we estimated DAH by US-based foundations other than BMGF from 1990 to 2010. BMGF, the largest foundation in the US,¹⁹ contributes more to DAH than all other US foundations combined. Because of this, we used a variety of data sources to estimate DAH from BMGF (Table 1). We separated commitments and disbursements by channel from BMGF for the period from 1999 to 2009 with preliminary disbursements for 2010.

Figure 9 shows that BMGF spending on DAH grew quickly from 2004 to 2008, increasing at an average annual rate of 39% before reaching \$1.80 billion in 2008, then plateauing in 2009. Between 2009 and 2010, disbursements from BMGF declined to slightly less than \$1.80 billion. More significantly, BMGF’s funding for future commitments has dropped sharply, from \$2.30 billion in 2008 to \$1.33 billion in 2009, a 42% drop in one year to the lowest level since 2005. This drop in commitments, however, should be interpreted with caution as BMGF’s global health commitments have fluctuated dramatically in the past due to large grants scheduled to be disbursed over many years.

As in last year’s report, the largest share of BMGF’s global health spending continues to flow to universities and research institutions. It also transfers a significant share of its funding to NGOs and other foundations and a small fraction to corporations, mainly for drug and vaccine development. Most of the remaining funds go to public-private initiatives for global health, particularly GFATM and GAVI, and multilateral institutions, including the World Bank and UN agencies.

DAH from other US foundations grew from \$116.45 million in 1990 to \$542.78 million in 2008, a 366%

increase. We analyzed the amount of total assets reported to the Foundation Center through 2009 and used the relationship between assets and spending, along with other factors such as GDP and stock market trends, to create a model that allowed us to estimate spending for 2009 and 2010. As a result, we estimate that, through the end of 2010, total DAH spending by foundations will have grown by just 1% since 2008. This is largely driven by a steep decline in total foundation assets, attributed in large part to the drop in world financial markets.²¹ Total assets for foundations other than BMGF dropped from a peak of \$697.03 billion in 2007 to an estimated \$567.80 billion in 2010, a 19% decline.²⁰

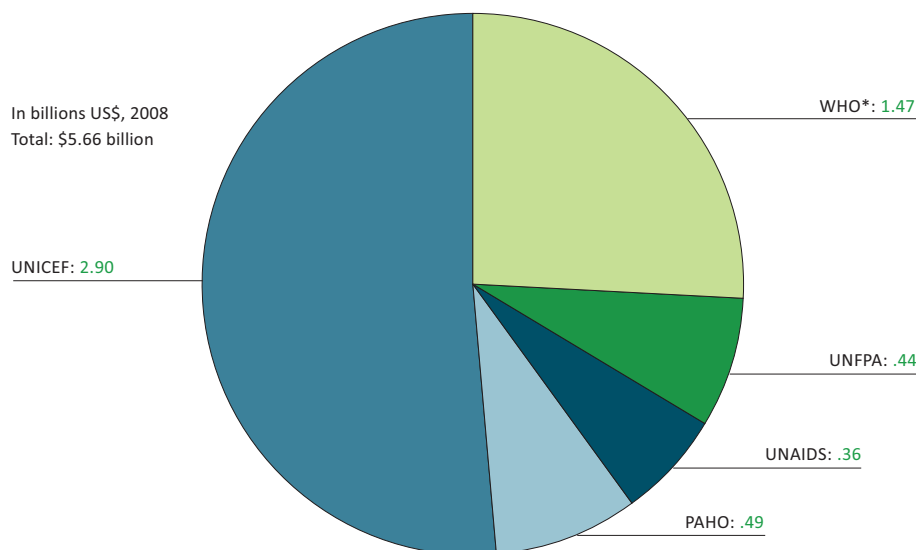
Multilateral organizations

International organizations, including the UN agencies, continue to provide a consistent amount of core funding for global health efforts. Yet their role has diminished in recent years with the advent of new global health actors such as BMGF, GAVI, and GFATM.¹ To better understand why their disbursement patterns have remained more constant than other organizations, we researched both their total expenditures since 1990 and their fund balances at the end of each year.

FIGURE 10:
Fund balances for UN health agencies at end of 2009

*WHO includes programmatic funds, as defined by “General Fund” in the 2008-2009 Financial Report.

Source: IHME DAH Database (UN) 2010



The amount that most UN agencies have disbursed for DAH grew at a much slower rate than DAH funding from other sources. Between 1990 and 2010, DAH channeled through UN agencies grew 87%, from \$2.00 billion to \$3.75 billion. All other channels combined saw an increase in the same period of 533%, from \$3.65 billion to \$23.12 billion. Since 2007, with the exception of WHO, UN agencies have seen an average annual growth rate in DAH between -1% and 3%. WHO has increased DAH by 8% annually. At the same time, the end-of-year fund balances for UN agencies have continued to climb. Figure 10 shows that for the five UN agencies responsible for nearly all DAH spending – WHO, the United Nations Children’s Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), and the Pan American Health Organization (PAHO) – the combined year-end fund balance for 2009 was \$5.66 billion, 52% more than what those agencies spent on DAH that year, as seen in Table 1 of the Statistical Annex.

In Figure 11, we compare fund balances over time to all expenditures, including DAH, for three UN health agencies. In 1991, UNFPA had a fund balance that amounted to 1% of its total spending that year. By 2009, its fund balance had grown to 55% of its total spending.

UNICEF’s fund balance was high at 95% in 1991 but dropped in subsequent years, reaching 62% in 1997. By 2009, though, UNICEF’s fund balance was \$2.90 billion, 90% as large as its total expenditure of \$3.23 billion. WHO nearly tripled its fund balance since 1991, from \$496.95 million to \$1.47 billion in 2009. During the same time frame, its spending grew at a slower pace of 57% to \$1.91 billion.

UN agencies may be responding to uncertain economic conditions by building their reserves, holding on to more funding in anticipation of future spending needs and declining donor contributions.

This may be prudent. Significant change in economic conditions can create stress on an agency’s budget. Increasing the size of fund balances may help agencies survive fiscal crises without jeopardizing core programs.^{22,23} The size of the fund balances, though, may indicate that the agencies are holding too much money in reserve, given the intense demands for DAH. There is no consensus on the ideal size for a year-end fund balance, but government analysts and auditors have said that fund balances of 5% or more of annual expenditure are considered healthy.²⁴

FIGURE 11:
Fund balances, annual expenditures, and fund balances as a percentage of annual expenditures for three UN agencies, 1991, 1997, 2003, and 2009

Annual expenditure includes all expenditure, including DAH.

■ Fund balance on Dec. 31
■ Annual expenditure

*WHO includes programmatic funds, as defined by “General Fund” in the 2008-2009 Financial Report.

Source: IHME DAH Database (UN) 2010

Notes: Percentages indicate fund balance as a percentage of annual expenditure. We developed methods to make estimates comparable across years, but changes in WHO accounting practices over time could have affected these corrections. For more information about our methods, please visit our online Methods Annex at: http://www.healthmetricsandevaluation.org/publications/financing_global_health_2010_methods_IHME.pdf

