CHAPTER 4

Sources of development assistance for health

Development assistance for health (DAH), by definition, is provided by governments and private organizations in high-income countries to low- and middle-income countries. The provision of DAH is thus influenced by the prevailing economic and political trends in Organisation for Economic Co-operation and Development (OECD) countries. The advent of austerity policies, across-the-board budget cuts, and, in some countries, steadfast commitments to development assistance in recent years have been the drivers of trends in sources of DAH. This chapter explores these sources, as distinguished by country of origin.

Figure 38 displays sources by the country of origin and type of funds. Despite the changes in the DAH landscape, governmental contributions still make up the vast majority of DAH. Non-governmental sources, such as corporate donations, foundations, and debt repayments make up only 23.5% of total DAH. The US government in particular remains the largest donor. In 2011, DAH originating in the US Treasury amounted to $11.2 billion. The creation of the Global Health Diplomacy unit and the increases in funding for the US President's Emergency Plan for AIDS Relief (PEPFAR) denote the US's continued support for global health.

The second largest contributor to DAH in 2011 was the UK government. Its provision of DAH amounted to $2.1 billion in 2011. In contrast to the US, the UK, led by Prime Minister David Cameron, has committed to increasing development assistance while also phasing out contributions to certain middle-income countries. In 2013, it was announced that UK development aid will also cease to target some low-income countries, such as Lesotho, Burundi, and 14 others.[51]

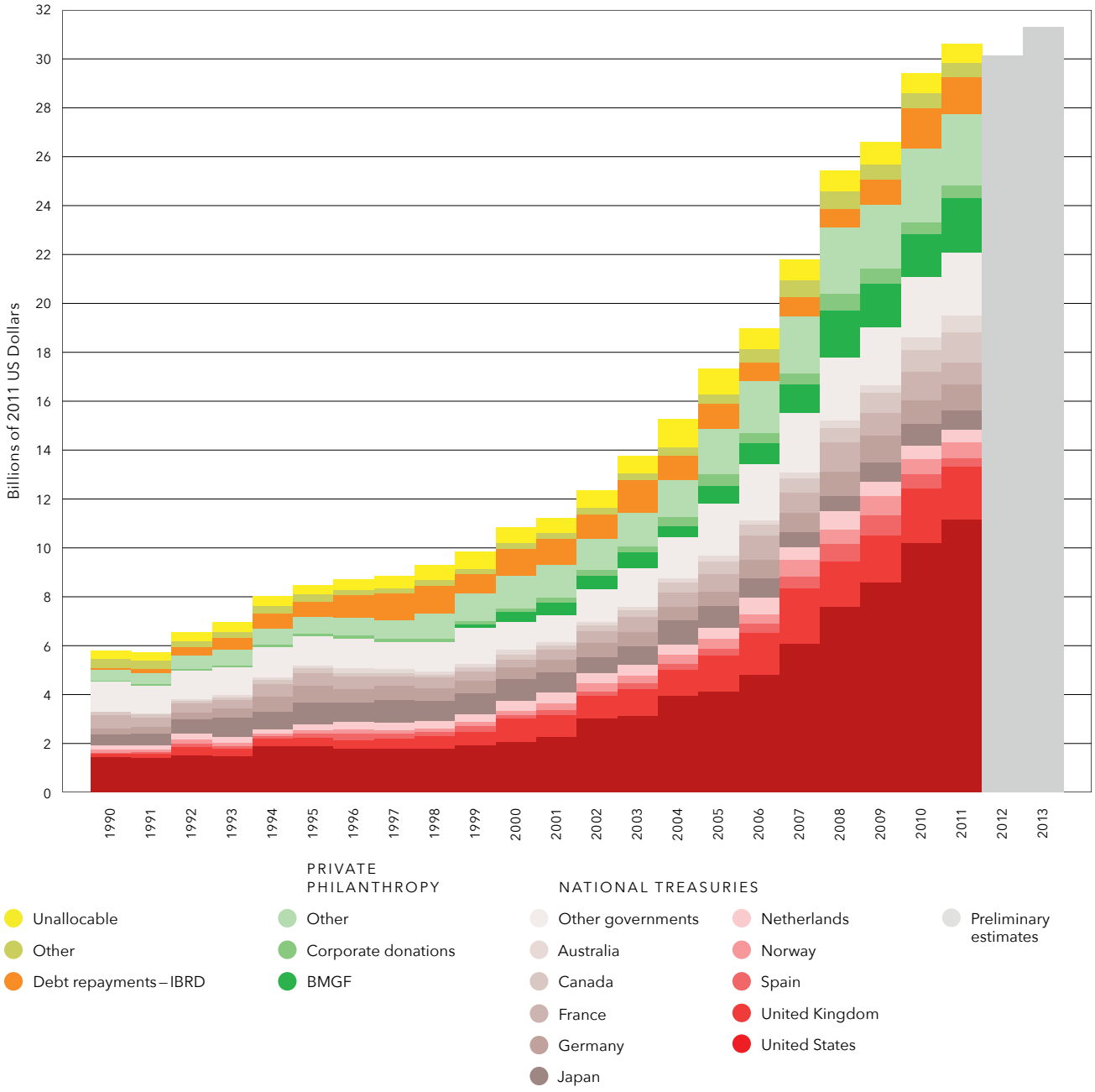
Across Europe, reductions in DAH were observed. Spain decreased its contribution to DAH by 34.2%, totaling just over $376 million in 2011. France, as well, provided less DAH. Its contributions reached $870 million in 2011, a 26.8% drop from 2010. Also slightly down were the Netherlands (4.2%) and Norway (2%), which contributed $528 million and $625 million, respectively, to global health in 2011.

Counteracting these cutbacks were a number of development assistance partners that bolstered their DAH in 2011. In contrast to most other European development assistance partners, Germany augmented DAH. Its contribution grew to $1.1 billion in 2011, a 14.4% increase over 2010. The Australian government provided more DAH as well. Its DAH disbursements grew to $694 million in 2011. Finally, Canada also increased spending. Total DAH sourced from the government of Canada was $1.3 billion in 2011, a 43% increase over 2010.

Private sources also expanded their contributions to DAH from 2010 to 2011. Notably, the investments made by the Bill & Melinda Gates Foundation (BMGF) were augmented by 29.9% over 2010. In 2011, BMGF as a source contributed $2.2 billion. Corporate donations topped $520 million in 2011, which was a 2.1% increase relative to 2010. A small portion of DAH cannot be traced to a specific source due to the format and information provided in datasets utilized. This year just 2.5% of DAH could not be allocated.

FIGURE 38

DAH by source of funding, 1990–2011



DAH AS A SHARE OF GROSS DOMESTIC PRODUCT

The Monterrey Consensus set an aid target of 0.7% of gross domestic product (GDP). A few countries have achieved this feat, including Denmark, Luxembourg, the Netherlands, Norway, and Sweden. Many others are far from meeting this target. The UK is one development assistance partner that continues its push toward 0.7% of GDP, although it has not yet attained this goal.[52]

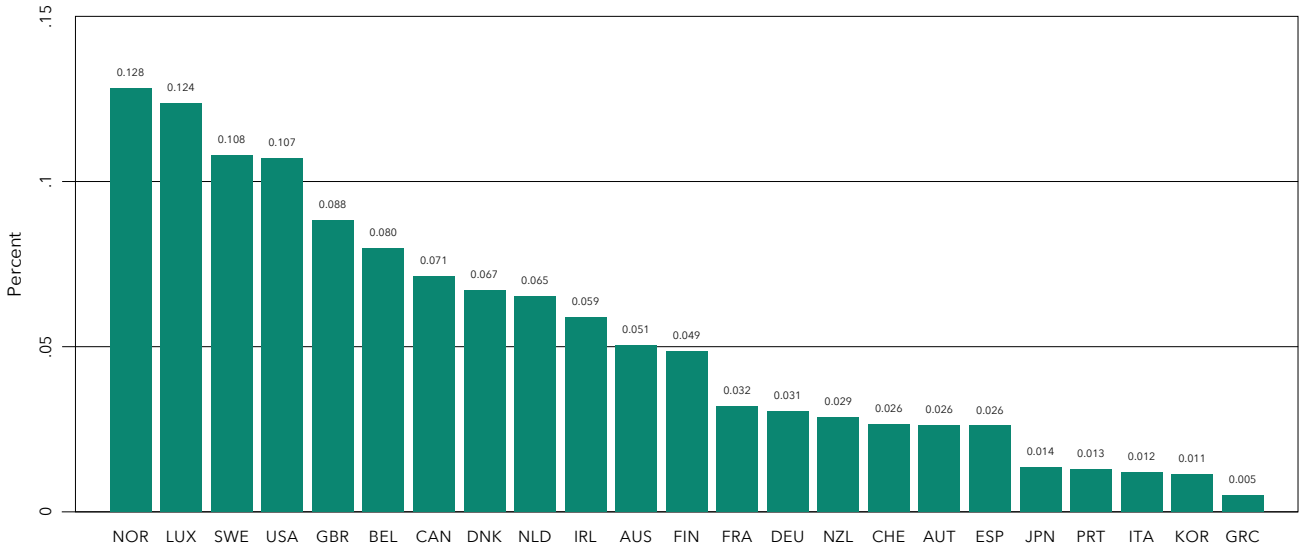
In an effort to illustrate how DAH aligns with the Monterrey target, Figure 39 displays DAH as a percentage of GDP. Governments are ranked left to right from highest to lowest. The order has changed little from 2010, although slight shifts have

Source: IHME DAH Database 2013

Notes: Funds from channels for which we were unable to find disaggregated revenue information as well as interagency transfers from non-DAH institutions are designated as "unallocable." "Other" refers to income from interest, currency exchange adjustments, and other miscellaneous sources of income. Due to data limitations, estimates are unavailable for DAH by source of funding for 2012 and 2013.

FIGURE 39

DAH as a percentage of gross domestic product, 2011



Sources: IHME DAH Database 2013 and World Bank World Development Indicators

Note: The countries included are the 23 members of the OECD-DAC.

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	Netherlands
NOR	Norway
NZL	New Zealand
PRT	Portugal
SWE	Sweden
USA	United States

occurred. As in 2010, Norway, Luxembourg, and Sweden lead OECD countries in providing the highest proportion of GDP as DAH. However, both Norway's and Luxembourg's shares dropped from 2010 to 2011, to 0.128% and 0.124%, respectively. The US moved up this year, to 0.107%, while the UK dropped to 0.088%. Greece, as in 2010, provided the lowest share of GDP as DAH, as it moved to phase out official development assistance entirely in the wake of its fiscal crisis.

PUBLIC SECTOR DAH

As discussed in Chapter 1, the types of channels prominent in global health have shifted over time. Public-private partnerships have disbursed a larger and larger share of DAH since their emergence on the global health scene around the turn of the 21st century. Figure 40 provides a static look at which governments tend to support public-private partnerships versus other types of channels, such as non-governmental organizations (NGOs), multilateral organizations, development banks, or countries' own bilateral institutions.

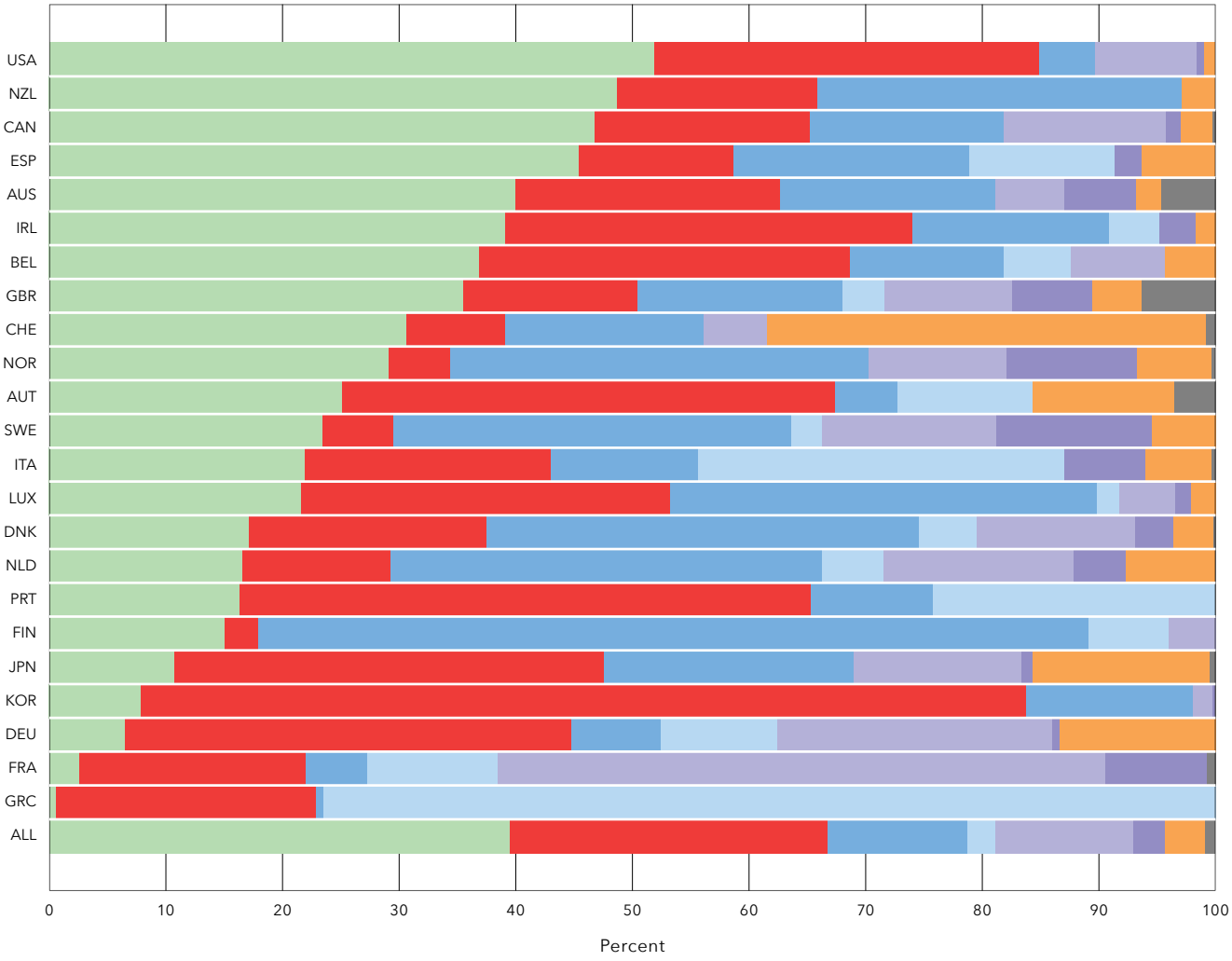
Overall, the US tends to be the biggest supporter of NGOs, as measured by share of US DAH. The US splits the major share of its funds across NGOs (51.8%) and bilateral agencies (33%). Relative to the share furnished by other countries, the US provides a minor portion of funds to the GAVI Alliance (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

Figure 40 also shows that the UK supports an array of channels. Like the US, the UK provides the bulk of its funds to NGOs (35.5%). However, the UK also provides 15% to bilateral agencies, 17.6% to the UN, and 3.6% to the European Commission (EC). Receiving 6.9% and 10.9%, respectively, the public-private partnerships of GAVI and GFATM also benefit from a considerable share of UK DAH.

As measured by portion of DAH, France is the most substantial supporter of GFATM, contributing 52.1% of its DAH to this public-private partnership. Also in contrast to the US, France provides very little of its DAH to NGOs: this funding amounted to just 2.6% in 2011.

FIGURE 40

Public sector DAH (donor-country-specific) by channel of assistance, 2011



UNITED NATIONS AND EUROPEAN COMMISSION

- Unspecified
- World Bank – IDA

GLOBAL HEALTH PARTNERSHIPS

- GAVI
- GFATM

UNITED NATIONS AND EUROPEAN COMMISSION

- European Commission
- UN agencies (WHO, UNICEF, UNAIDS, UNFPA)

BILATERAL AGENCIES

- Governments

NON-GOVERNMENTAL CHANNELS

- NGOs, public-private partnerships, other

Source: IHME DAH Database 2013

Notes: The composition of DAH from the 23 member countries of the OECD-DAC is shown. "Unspecified" indicates that the donor country did not report the specific channel to which DAH was provided.

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	Netherlands
NOR	Norway
NZL	New Zealand
PRT	Portugal
SWE	Sweden
USA	United States

Across all development assistance partners, South Korea most heavily favors bilateral channels, providing 75.9% of its DAH through this mode of delivery. South Korea provides very little through NGOs (7.8%) and public-private partnerships (1.9%). South Korea does contribute a minor share to UN agencies (14.3%).

One of the biggest supporters of UN agencies, as measured by proportion of DAH, is Finland. In 2011, Finland provided 71.2% of its DAH to these entities. Finland, however, did not provide much to NGOs (15.1%), GFATM (4%), and the EC (6.8%).

More than any other country, Switzerland tends to commit a large share of funds to the World Bank's International Development Association (IDA). In 2011, it contributed 37.6% to IDA, far beyond the share of any other development assistance partner. Switzerland also provided a substantial portion of funds to NGOs (30.6%) and UN agencies (17%) but very little to its bilateral organizations (8.5%) and GFATM (5.4%). Other types of channels were not supported with Swiss funds.

SOURCE OF PUBLIC-PRIVATE PARTNERSHIPS' RESOURCES

Public-private partnerships were established to streamline efforts to address a few key global health areas, with a view to improving the effectiveness of each DAH dollar, and have grown substantially since their inception. This section outlines which sources have been fundamental to this expansion. Examining the sources of funds shows that while GFATM has received support from an array of development assistance partners, GAVI's start-up funds were sourced from just a few key players.

Figure 41 shows the origins of support for GFATM from 2002–2011. Since the inception of GFATM, the United States has been the biggest contributor. Its contribution to GFATM has ranged from 19.6% to 33.4% over this period. GFATM's next-biggest development assistance partner is France. In 2011, the share provided by France was substantial, making up 15.5% of Global Fund receipts. French funds have not dipped below 6.1% of Global Fund financing throughout the course of the organization's existence. Other major contributors in 2011 were the UK (8%) and Germany (8.7%), both of which have consistently supported GFATM. Falling from the pack of contributors in 2011, Italy refrained from providing support, despite having been one of the major donors at the launch of GFATM. The EC also did not contribute in 2011.

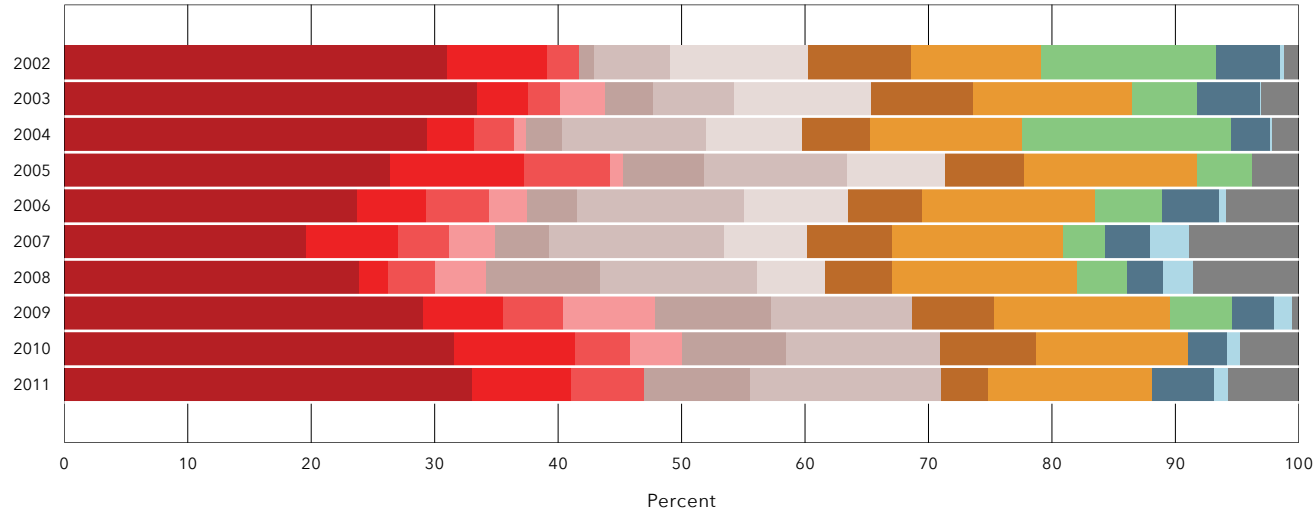
The trends underpinning GAVI support are substantially different. Figure 42 shows that BMGF played a crucial role in launching GAVI. In 2000 and 2001, BMGF provided the vast majority of funds, upward of 98.6% and 82%, respectively. By 2002, other development assistance partners had stepped in, with major funding from the US (49.2%), Norway (19.8%), UK (13.9%), and Netherlands (12.4%). By 2011, GAVI received financial support from a wide range of partners. BMGF regained its slot as top donor, providing 26.5% in 2011. The UK followed, contributing 18.1%. Substantial support was also provided by other development assistance partners in 2011, including the US (9%), France (9.4%), Norway (8.6%), Sweden (9.4%), and the Netherlands (2.9%).

NON-GOVERNMENTAL ORGANIZATIONS

NGOs play a key role in the delivery of DAH. NGOs act as channels, facilitating the transfer of funds from OECD countries to low- and middle-income countries. NGOs also contribute to the direct delivery of health services, serving as health facilities, vaccinating children, and running public health campaigns. The global health landscape would operate very differently in the absence of NGOs. While NGOs act independently to mobilize funding from public and private donors, many also join forces to strengthen fundraising efforts and bolster their influence. NGO alliance

FIGURE 41

GFATM revenue by source, 2002–2011



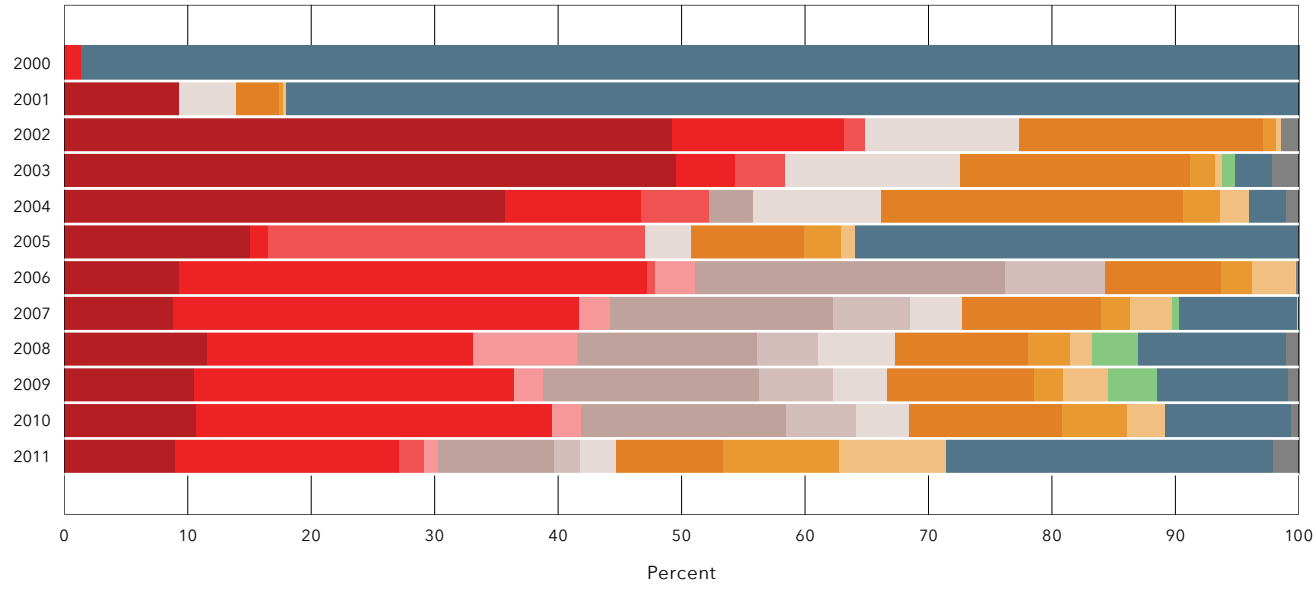
United States
United Kingdom
Canada
Spain
Germany
France
Italy
Japan
Other bilaterals
European Commission
BMGF
Other private
Unspecified

Source: IHME DAH Database 2013

Note: "Other private" refers to contributions from the private sector, less funds from BMGF.

FIGURE 42

GAVI Alliance revenue by source, 2000–2011



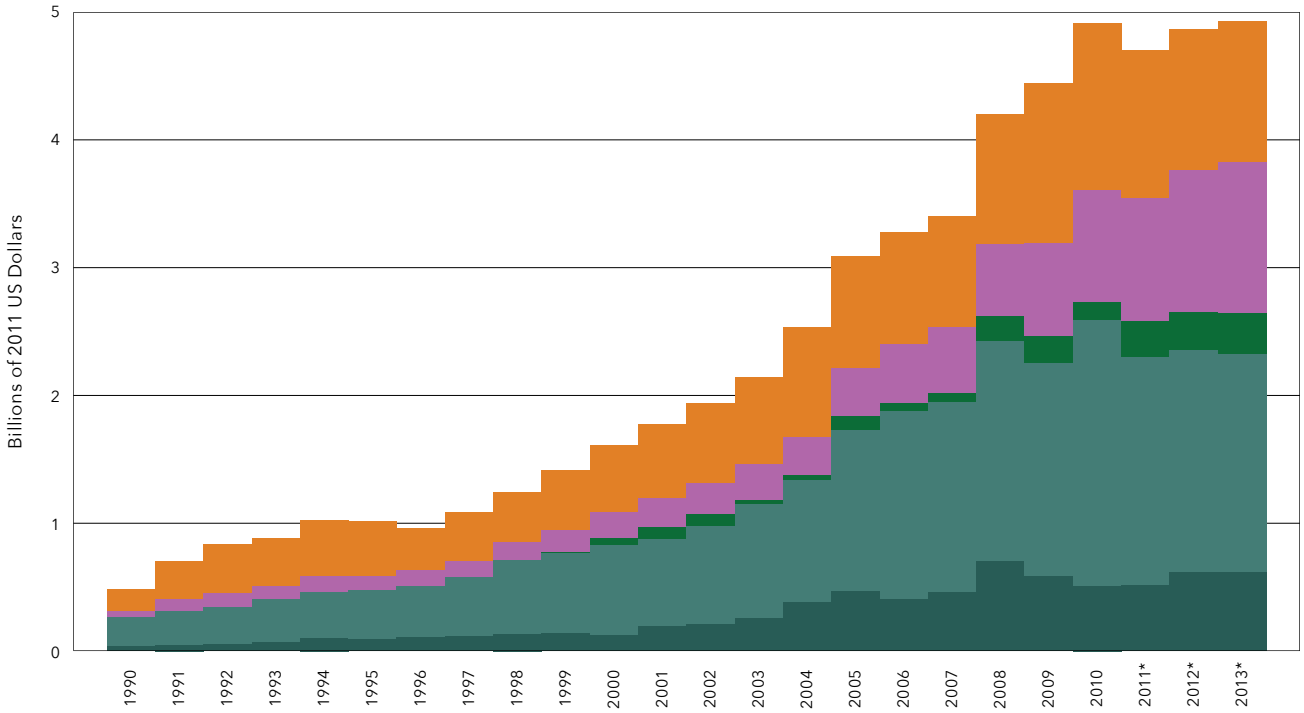
United States
United Kingdom
Canada
Spain
France
Italy
Netherlands
Norway
Sweden
Other bilaterals
European Commission
BMGF
World Bank
Other private

Source: IHME DAH Database 2013

Note: "Other private" refers to contributions from the private sector, less funds from BMGF.

FIGURE 43

Total overseas health expenditure by NGOs, 1990–2013



- US public
- Other public and international organizations
- BMGF
- Private financial contributions
- Private in-kind donations

Source: IHME DAH Database 2013

Notes: Total health spending is disaggregated by shares of revenue received from the US government, other public sources of funding, international organizations, BMGF, financial donations from private sources, and in-kind donations from private sources. Data cover NGOs registered with USAID.

*Data from 2011–2013 are based on preliminary estimates.

organizations, such as InterAction and CONCORD, have been conceived or have grown dramatically since the launch of the Millennium Development Goals.

Overall, the NGO growth trend is similar to total DAH. As depicted in Figure 43, the 1990–2000 period is marked by steady but slow growth, while DAH grew rapidly in the 2001–2010 era. From 2011 onward, growth has slowed according to preliminary estimates. Total NGO spending was an estimated $4.9 billion in 2013, providing 15.7% of total DAH in 2013.

Figure 43 also provides the origin of support for NGOs. Funding originates in both public and private sources, with the bulk of funds provided by other public and international organizations (23.9%). This source of funds grew slightly by 6.2% from 2012 to 2013, with total contributions amounting to $1.2 billion in 2013. The US public, which comprises the US government's financial contributions, also provided 22.3%, or $1.1 billion, in 2013.

In recent years, private sources, including financial and in-kind contributions from private companies, philanthropies (excluding BMGF), and individuals, have supplied more in NGO DAH than combined public funding. NGOs' ability to mobilize private funding to improve health in developing countries may help explain why they have succeeded in increasing their spending in contrast to other channels that have relied primarily on a shrinking pool of public funding. In 2013, private financial contributions alone were responsible for $1.7 billion in NGO DAH. Private in-kind contributions, such as donations of drugs or vaccines, were also substantial in 2013. This source provides 12.5% of funds, a total of $617 million. BMGF supported NGOs with $327 million in 2013, an 11.1% rise over 2012.

Table 1 displays the top 20 US-based NGOs by cumulative spending over 2007–2010. Leading this group is Population Services International, spending $1.4 billion

TABLE 1

US-based NGOs with highest cumulative overseas health expenditure, 2007–2010

Rank	Organization	Overseas health expenditure, adjusted	Overseas health expenditure, unadjusted	Overseas expenditure, unadjusted	Percent of revenue from private sources	Percent of revenue from in-kind contributions
1	Population Services International	1392.35	1392.36	1784.37	17.72	0.00
2	Catholic Relief Services	910.90	916.74	2750.85	32.11	0.85
3	Food for the Poor	793.18	3009.92	4709.03	98.55	90.08
4	PATH	667.75	683.20	799.46	78.67	2.91
5	Clinton Health Access Initiative	626.77	631.74	709.96	55.57	1.11
6	Management Sciences for Health, Inc.	577.22	577.22	609.58	0.77	0.00
7	Elizabeth Glaser Pediatric AIDS Foundation	411.98	413.23	434.94	15.60	0.37
8	CARE	355.95	358.28	2418.42	29.20	0.79
9	Save the Children	319.19	334.16	1701.05	50.34	5.70
10	World Vision	312.68	418.08	3440.61	78.01	30.81
11	Pathfinder International	307.76	310.04	354.37	22.83	0.85
12	MAP International	292.88	1384.72	1509.19	99.51	96.67
13	International Medical Corps	276.74	397.24	414.48	49.65	37.05
14	Rotary Foundation of Rotary International	271.83	271.83	587.14	99.99	0.00
15	Brother's Brother Foundation	239.60	1277.34	1919.16	99.96	99.36
16	Academy for Educational Development	232.72	233.93	943.28	11.21	0.62
17	Project HOPE	230.00	593.09	643.90	94.00	75.02
18	United Nations Foundation	219.47	230.85	342.12	88.30	8.63
19	Catholic Medical Mission Board	217.70	877.54	928.34	99.37	91.99
20	Feed the Children	212.60	738.36	2114.31	99.64	87.13

Source: IHME DAH Database 2013

Notes: Expenditures shown in millions of 2011 US dollars. Overseas health expenditure for 2011–2013 is not included because of data limitations. Data reflect NGOs registered with USAID. Adjusted overseas health expenditure reflects deflated private in-kind donations plus unadjusted financial assistance.

TABLE 2

Internationally based NGOs with highest cumulative overseas health expenditure, 2007–2010

Rank	NGO	Overseas health expenditure	Overseas expenditure	Percent of revenue from private sources
1	Save the Children Fund, United Kingdom	281.54	1307.32	62.37
2	Marie Stopes International	273.47	388.54	92.31
3	Handicap International	227.51	316.13	84.39
4	Medical Emergency Relief International	222.45	286.23	40.00
5	International Union Against Tuberculosis and Lung Disease	146.27	189.78	76.38

Source: IHME DAH Database 2013

Note: Expenditures shown in millions of 2011 US dollars.

over the period, followed by Catholic Relief Services, with $911 million in expenditure. The increase in spending by World Vision boosted the organization in the list of NGOs. World Vision spent $313 million from 2007 to 2011. No new organizations appeared on the top 20 list in *Financing Global Health 2013*, reflecting an emerging stability among major NGOs.

To better quantify non-governmental spending on global health, IHME took special care to estimate the DAH provided by internationally based NGOs in this year's report. NGOs are considered "internationally based" if their headquarters and tax base are located outside the US. The top five internationally based NGOs are displayed in Table 2. Topping the list was Save the Children Fund, UK, which provided $282 million in DAH. Marie Stopes International was a close second, with $273 million in expenditure across 2007–2010.

BOX 3

Non-governmental organization estimates

This year, the Institute for Health Metrics and Evaluation (IHME) made a special effort to include NGOs based outside as well as inside the US, a substantial improvement on previous estimates. Tracking focuses on NGOs that receive funding from the US government because systematic reporting of worldwide NGO spending is not currently available. By combining data provided by the US government on total NGO expenditure with a series of estimation methods, IHME developed updated, expanded estimates of the DAH provided by NGOs in *Financing Global Health 2013*.

OTHER SOURCES

Increasingly, middle-income countries, such as China, Turkey, South Africa, Brazil, and India provide health-related support to low-income countries. While some official development assistance is provided, transfer of technology, private investments, and other types of south-south cooperation are also part of this support. Middle-income countries have been involved in global health by working to improve access to medicines, supporting HIV/AIDS and malaria interventions, augmenting disease surveillance, and other capacity-building efforts.[53]

Unfortunately, although data are available on the contributions made by OECD countries, little is still known about the magnitude and scope of DAH provided by some of the emerging development assistance partners. In 2013, some initial forays into estimating these sums were made by AidData, which estimated the development assistance provided by China.[54,55] Even so, because of data quality issues, *Financing Global Health 2013* cannot provide estimates of middle-income countries' DAH. IHME looks forward to integrating these contributions in the future as better data become available.