



## CHAPTER 2:

# DEVELOPMENT ASSISTANCE FOR HEALTH

The foremost goal of this research is to estimate the total volume of health assistance from 1990 to 2007. In this chapter, we present our estimates of total health assistance from 1990 to 2007 and analyze the relative share of different channels, funding sources, countries of origin, and types of contributions. All estimates are presented in 2007 US dollars.

### By channel of assistance

Figure 5 presents the total envelope of development assistance for health (DAH) by year, disaggregated by channels of assistance. It is hard to miss the dramatic rise in total health assistance from 1990 to 2007 in the graph. Between 1990 and 2007, DAH quadrupled in volume from \$5.6 billion to \$21.8 billion. The figure also shows that the rate of growth has not been constant over this duration. Health assistance grew gradually in the 11 years from 1990 to 2001, roughly doubling from \$5.6 billion to \$10.9 billion. It took only six years for it to double again from \$10.9 in 2001 to \$21.8 in 2007.

The total volume of aid in each year is disaggregated further into the individual contributions from each of the following channels: bilateral agencies, regional development banks, the two arms of the World Bank – the International Development Association (IDA) and the International Bank for Reconstruction and

Development (IBRD) – the United Nations (UN) agencies, the European Commission (EC), Global Alliance for Vaccines and Immunization (GAVI), Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM), Bill & Melinda Gates Foundation (BMGF), other US-based foundations, and US-based non-governmental organizations (NGOs) tracked in the study. For each of them, the graph shows their total financial and in-kind health-related contributions, net of any transfers to other channels also tracked by IHME. For example, a large share of the revenue received by US-based NGOs was from the US government. We subtracted the share of expenditure that was financed through contributions from the US government from the assistance attributed to bilateral aid. For BMGF, this figure shows its total disbursements net of any funds it transferred to other channels in the study.

Examining the composition of health assistance by channel reveals that the relative contributions of different channels have changed considerably over the years. The share of health assistance from bilateral agencies decreased from 46.8% in 1990 to 27.1% in 2001, and then increased in subsequent years to 34% in 2007. The percent of total health assistance flowing from UN agencies decreased from 32.3% in 1990 to 14% in 2007. The World Bank and regional banks accounted for 21.7% of total health assistance at their

relative peak in 2000. That percentage dropped to 7.2% by 2007. GFATM and GAVI scaled up rapidly from less than 1% of health assistance each in 2002 to 8.3% and 4.2% respectively in 2007. BMGF as a channel peaked in 2007 at 3.9% of health assistance. The share of resources flowing through NGOs increased from 13.1% of health assistance in 1990 to 24.9% in 2006, the last year for which we have reported data for the NGOs.

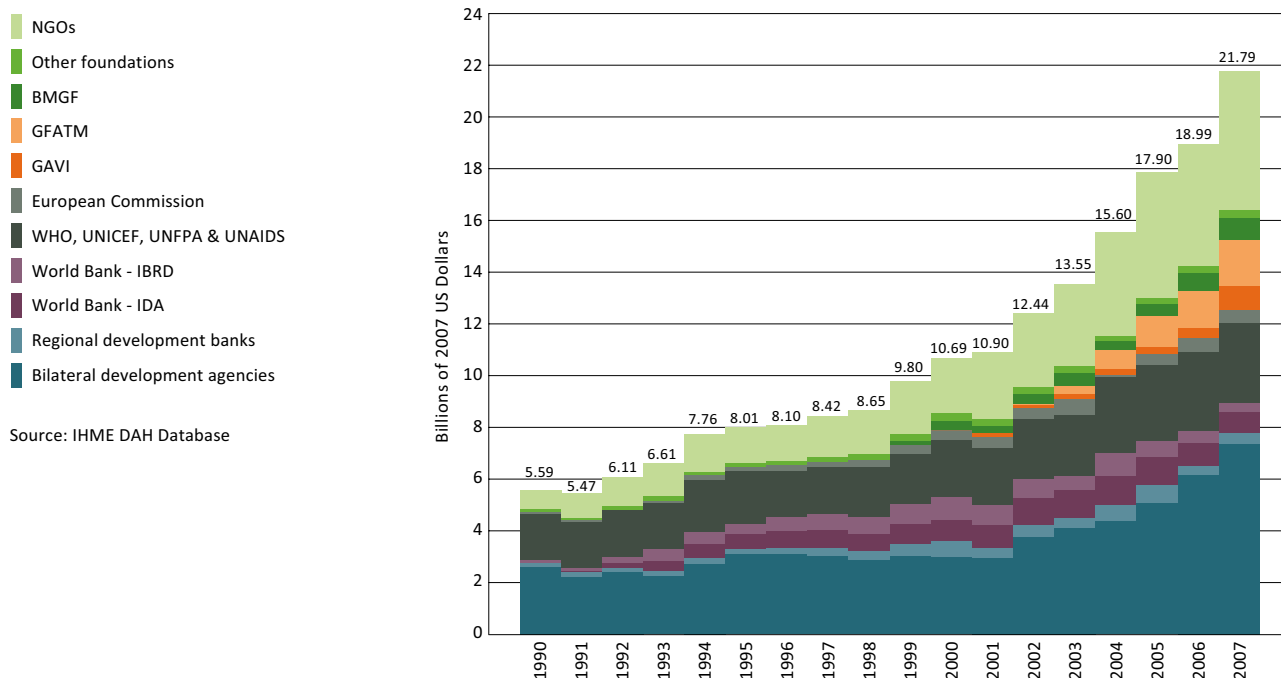
### By source of funding

Figure 6 shows the disaggregation of DAH each year by the share that was funded by different sources. It is worth noting that the figure does not show the amount of funds that flowed from each of the funding sources to the channels, but rather the share of total development assistance that is attributable to different funding sources. For example, the World Health Organization’s (WHO) total health contributions are disaggregated into the shares that it received from different national treasuries and private contributions.

Contributions from donor governments accounted for nearly two-thirds of total DAH flowing to developing countries. As a percent of total, their contributions ranged from 60% to 76% in the years covered by the study. The US government was the single largest donor of public DAH during this entire time period. Other big donors included the governments of the UK, Japan, Germany, France, the Netherlands, Canada, Sweden, Norway, and Italy. Even though we did not track bilateral aid from non-Organisation for Economic Co-operation and Development (OECD) countries separately, to the extent that countries make contributions to any of the channels tracked by the study, they are reflected in this graph. Hence, “other governments” in Figure 6 include both OECD governments not shown separately in the figure as well as expenditures financed by contributions from non-OECD countries.

The figure also shows that private sources of funding were responsible for a growing share of total health assistance, up from 19% in 1998 to 26.7% in 2007. The

**FIGURE 5**  
Development assistance for health from 1990 to 2007 by channel of assistance

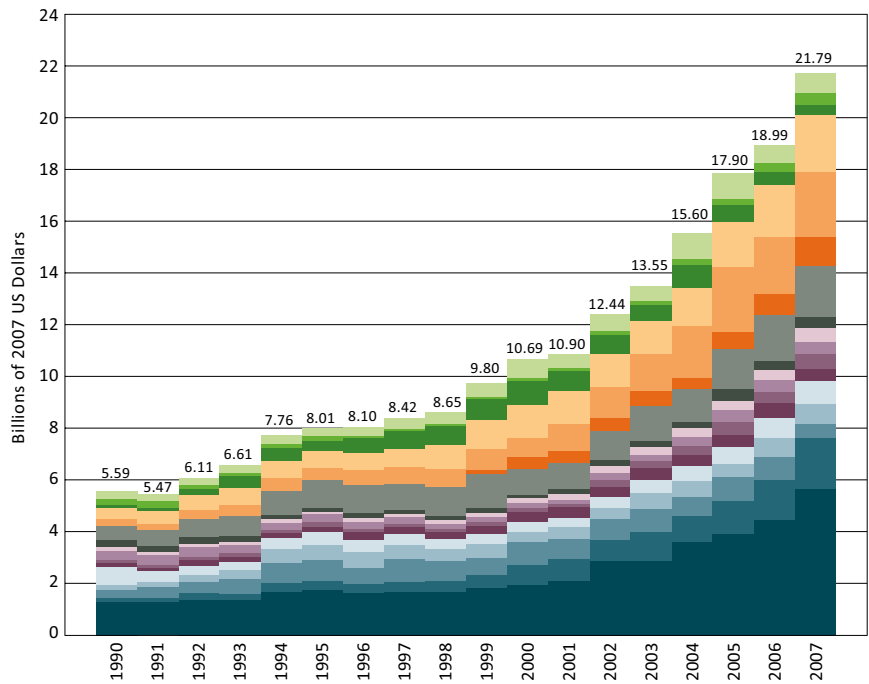


**FIGURE 6**

**Development assistance for health from 1990 to 2007 by source of funding**

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

- Unallocable
- Other
- Debt repayments (IBRD)
- Private philanthropy:
  - Other
  - Corporate donations
  - BMGF
- National treasuries:
  - Other governments
  - Italy
  - Norway
  - Sweden
  - Canada
  - Netherlands
- France
- Germany
- Japan
- United Kingdom
- United States



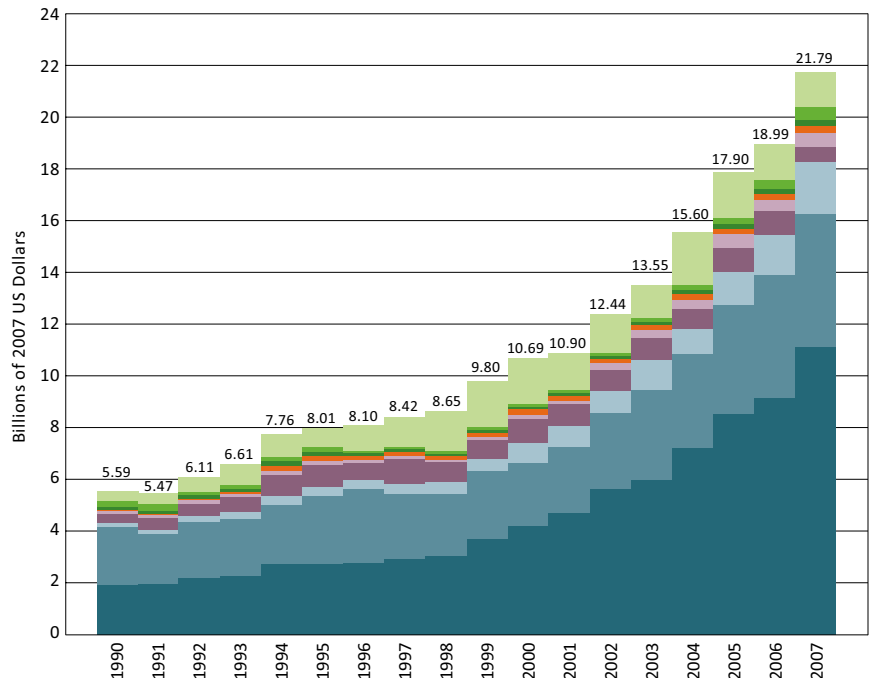
Source: IHME DAH Database

**FIGURE 7**

**Development assistance for health from 1990 to 2007 by country of origin**

"Unallocable" includes funds like inter-agency transfers from non-DAH institutions, interest income, and miscellaneous income that could not be attributed to countries due to their nature. Channels for which we had no revenue information are included under "unspecified."

- Unspecified
- Unallocable by donor
- Other
- Australia & New Zealand
- Canada
- Japan
- United Kingdom
- Europe excluding UK
- United States



Source: IHME DAH Database

share of health assistance financed by private philanthropy is further broken into its largest constituent parts. BMGF as a source includes both BMGF's contributions as a channel of assistance and the amount of flows from other channels that can be attributed to the funds received from BMGF. Counted this way, BMGF is one of the main sources of privately financed health assistance. Contributions from private corporations to US-based NGOs constitute another large component of privately financed health assistance. In-kind donations of drugs and medical equipment from pharmaceutical companies are included in this category. In the data reported by the NGOs, these donations were sometimes valued at current market prices. This accounting practice has potentially resulted in an exaggeration of the magnitude of resources flowing via US NGOs and, in turn, the share of total assistance that can be attributed to corporate donations. This issue is discussed in detail in Chapter 4. All private charitable donations as well private giving from US-based foundations besides BMGF are included in the residual category.

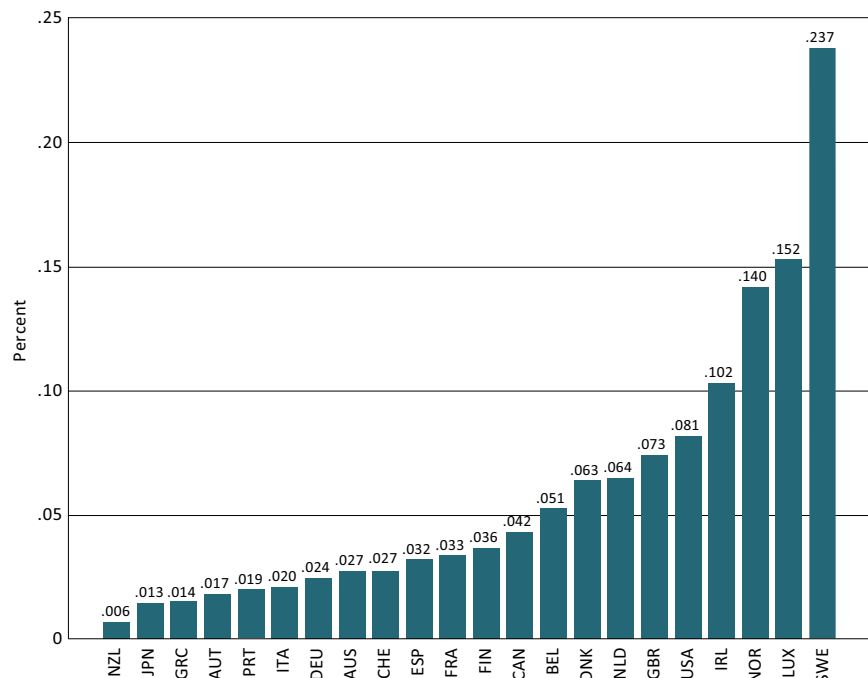
### By country of origin

Figure 7 shows the disaggregation of total health assistance by its country of origin. To do this, we combined all health resources financed by US-based actors, regardless of whether those funds were public contributions from the national treasury, or private donations from US-based philanthropists and corporations, into a common pool representing the total of US contributions. It is worth noting that private contributions from citizens of other donor countries to NGOs in their countries were not quantified due to data limitations. To put this into context, the eight largest non-US NGOs for which we found some data spent \$231 million on health programs in 2006, which is small in comparison to the health expenditures of US NGOs. Hence, we believe that the overall pattern is still largely as shown, despite the exclusion of non-US NGOs. The figure shows that with respect to the volume of health aid, the US was the biggest contributor from 1990 to 2007 and its share has increased over the years. European countries contributed the

**FIGURE 8**  
Development assistance for health as a percent of national income in 2007

- 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
- LUX = Luxembourg
- NLD = the Netherlands
- NOR = Norway
- NZL = New Zealand
- PRT = Portugal
- SWE =Sweden
- USA = United States

Source: IHME DAH Database and World Bank World Development Indicators



second largest share of health assistance, followed by Japan and Canada.

This comparison, however, disregards differences in national incomes across these countries. Figure 8 shows health assistance from each of the 22 member countries of the OECD-DAC in 2007 as a fraction of their national incomes, measured in terms of their gross domestic product (GDP) in the same year. At the high end, Sweden’s health aid represented 0.23% of its national income in 2007. At the other extreme, New Zealand’s contribution amounted to less than 0.01% of its GDP. By this measure, the US ranks fifth among the 22 donor countries, behind Sweden, Luxembourg, Norway, and Ireland. The inclusion of private monies in the US contribution to DAH causes this donor to rank dramatically higher than it would if the US government’s DAH alone was counted.

### By target region

Figure 9 provides a regional breakdown of health assistance. For some of the channels tracked in the study, the data we have collected did not allow us to ascertain the target region. For example, we were unable to disaggregate health expenditures by US-based NGOs according to the regions of the world in which the NGOs implemented their programs. This is distinct from funds that had no country target, which correspond to contributions made towards health research and the generation of other global public goods and are shown in this graph as “global.”

The figure shows that all regions saw increases in funding, but the relative share of health assistance for sub-Saharan Africa increased from 9.7% in 1990 to 13.8% in 2001, and then to 22.7% in 2007. This growth in part reflects the massive expansion of funding for HIV/AIDS. The figure also shows that health assistance

**FIGURE 9**  
Development assistance for health from 1990 to 2007 by focus region

Health assistance for which we have no recipient country or region information is coded as “unallocable.”



Source: IHME DAH and project databases

that is global in nature, which includes funds for health research, has grown considerably in recent years.

### By type of assistance

Figure 10 shows the disaggregation of DAH by the type of assistance provided into financial transfers and in-kind contributions. Financial transfers include all gross disbursements from health assistance channels to implementing agencies and research institutions in both high-income countries and developing countries through grants and concessionary loans. In-kind assistance has two components. The first – program management, research, and technical assistance – includes all expenditures by UN agencies on health programs, the costs incurred by loan- and grant-making institutions for providing technical assistance and program management, and expenditures by NGOs net of any commodities delivered. Donated drugs and other commodities comprise the second component of in-kind transfers and are shown separately.

While discussions on development assistance have hitherto focused primarily on financial transfers in the form of loans and grants, this figure shows that the in-kind share of health assistance is large and has grown over time.

Whether staff hired from donor countries to administer health programs and provide technical assistance represent “phantom aid” or provide useful and much-needed training and expertise is a much-debated question.<sup>31</sup> The effectiveness of such in-kind contributions is a research question in its own right which deserves careful analysis.

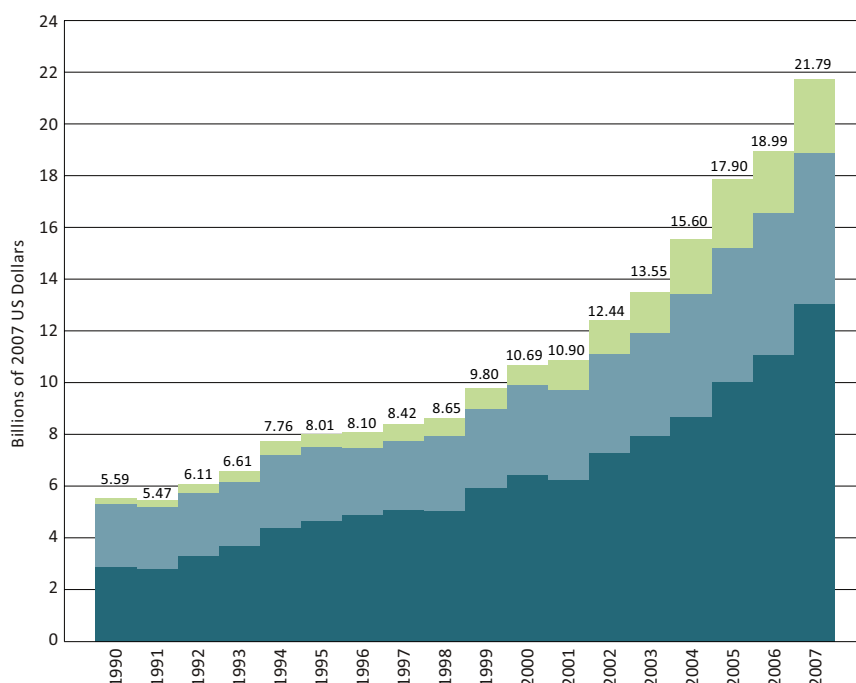
### By health focus

Given current debates about disease-specific vertical program support and general health system support, we analyzed the volume of development assistance earmarked for three priority diseases among donors – HIV/AIDS, tuberculosis, and malaria – as well as

**FIGURE 10**  
Development assistance for health from 1990 to 2007 by type of assistance

- Transfers:
- In kind: Commodities (drugs & supplies)
  - In kind: Management, research, technical assistance
  - Financial: Grants & loans

Source: IHME DAH Database



support for sector-wide approaches and health systems strengthening. This analysis was only possible for a subset of the channels tracked by the study, where we were able to break down the channels' total health contributions by disease. Only GFATM currently provides data already coded by disease focus. In all other cases, we used project-level information when it was available to disaggregate the channels' total health flows by disease. Specifically, we used the descriptive fields in the data, such as the project title and project description. We assumed that all expenditure by the Joint United Nations Programme on HIV/AIDS (UNAIDS) was for HIV/AIDS. We were able to find a disease-wise breakdown of expenditures made by WHO. Figure 11 shows the results from this analysis. This disaggregation reflects the contributions of bilateral agencies, EC, GFATM, GAVI, the World Bank, the Asian Development Bank (ADB), the Inter-American

Development Bank (IDB), BMGF, WHO and UNAIDS. All others are lumped together as "unallocable."

The trends show that disbursements for HIV/AIDS grew, first gradually from \$0.2 billion in 1990 to \$0.7 billion in 2000, and then more rapidly to \$4.9 billion in 2007. Development assistance for tuberculosis and malaria remained small in comparison: \$0.6 billion and \$0.7 billion respectively in 2007. However, resources for malaria have shown substantial increases since 2005. The figure also shows health sector support funds mobilized through partner coordination mechanisms. Despite the strong rhetoric from donors on the importance of providing funds for sector-wide approaches that are not linked to specific programs or diseases, the volume of these flows remained low. More information on the relationship between health assistance and disease can be found in Chapter 6.

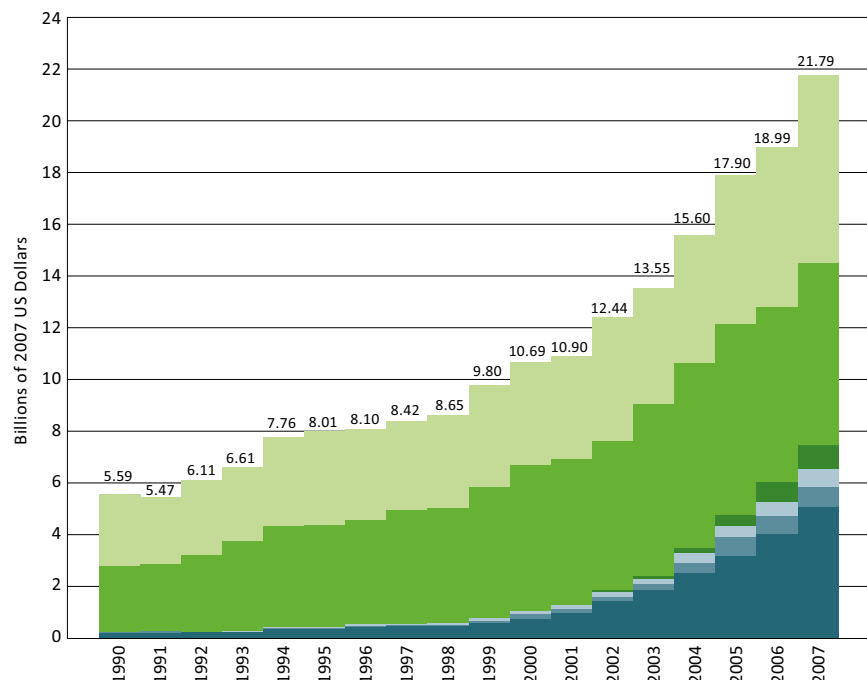
**FIGURE 11**

**Development assistance for health from 1990 to 2007 for HIV/AIDS, tuberculosis, malaria and health sector support**

"Unallocable" corresponds to DAH for which we did not have project level information on disease-focus.

- Unallocable
- Other
- Health sector support
- Tuberculosis
- Malaria
- HIV/AIDS

Source: IHME DAH and project databases



#### BOX 4

##### Comparing aid for health with aid for other sectors

This study documents the dramatic rise in health aid. Are these gains representative of a general increase in all types of aid? Or has health aid as a share of total aid grown over the years, which implies that it has displaced aid to other sectors?

To answer these questions correctly, we would need to conduct a second resource tracking exercise to estimate the total envelope of development assistance from all public and private channels of assistance. We plan to do that in future years. In the meantime, we include here two comparisons of health aid with other resource flows to provide a preliminary answer to this question.

The first comparison uses estimates of bilateral assistance from the Development Assistance Committee of the Organisation for Economic Co-operation and Development's (OECD-DAC) databases, also called bilateral official development assistance (ODA). "Official" refers to the fact that these estimates only reflect aid from donor governments and not private contributions. Figure 12 shows estimates of total bilateral assistance from these data. These include sector-specific assistance as well as general non-sector-specific aid, such as general budget support (GBS), debt relief, and humanitarian assistance. Sector-specific aid includes all assistance flowing to areas such as health, education, and water and sanitation. In the case of GBS, the donor gives funds to recipient governments without earmarking for use in any particular sector. In the case of debt relief, a donor forgives outstanding debt. Figure 12 also shows sector-specific aid and aid for the health sector. Finally, it shows health aid as a fraction of all aid and sector-specific aid.

Total bilateral assistance fluctuated in the 1990s, increased dramatically from 2001 to 2005, and dropped in the subsequent two years. Aid for development-related sectors also fluctuated in the 1990s but grew steadily from 2001 to 2007. Bilateral assistance for health both as share of total aid and sector-allocable aid has increased from 1990 to 2007. Hence, the rise in health sector assistance has been greater than the rise in aid for other sectors combined.

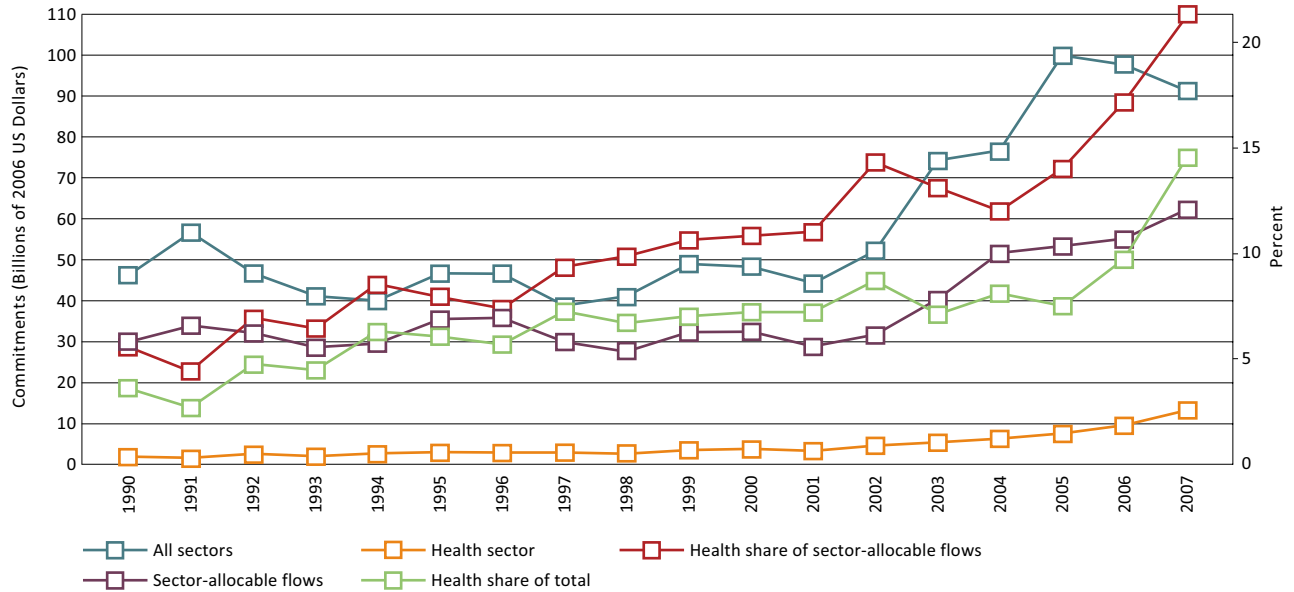
The second comparison addresses current discussions in the development assistance community about the impact of GBS and debt-relief on health. Some donors, particularly the UK and the EC, have channeled an increasing amount of their development aid into GBS instead of sector-specific aid. GBS gives country governments control over how and where the funds are spent. Such grants, along with debt relief, have the potential to increase resources for the health sector, despite not being earmarked for health *per se*. Hence, to put development assistance for health numbers in perspective, Figure 13 shows our estimated trend for GBS disbursements and debt relief. The figure also shows the additional dollars that flowed into the health sector in developing countries as a result of GBS and debt relief assuming that developing country governments spent 5% of the resources on health. On average, developing countries spend 8% of their total budgets on health, which includes external funds received specifically for use in the health sector. Given the influx of donor funding for the health sector, governments are likely to spend a lower fraction of funds they control, and therefore GBS, on health. The results show that the amount of health dollars that GBS and debt relief generated was small (less than \$0.3 billion in 2007) in comparison to health assistance.



**FIGURE 12**

**Bilateral ODA commitments from 1990 to 2007**

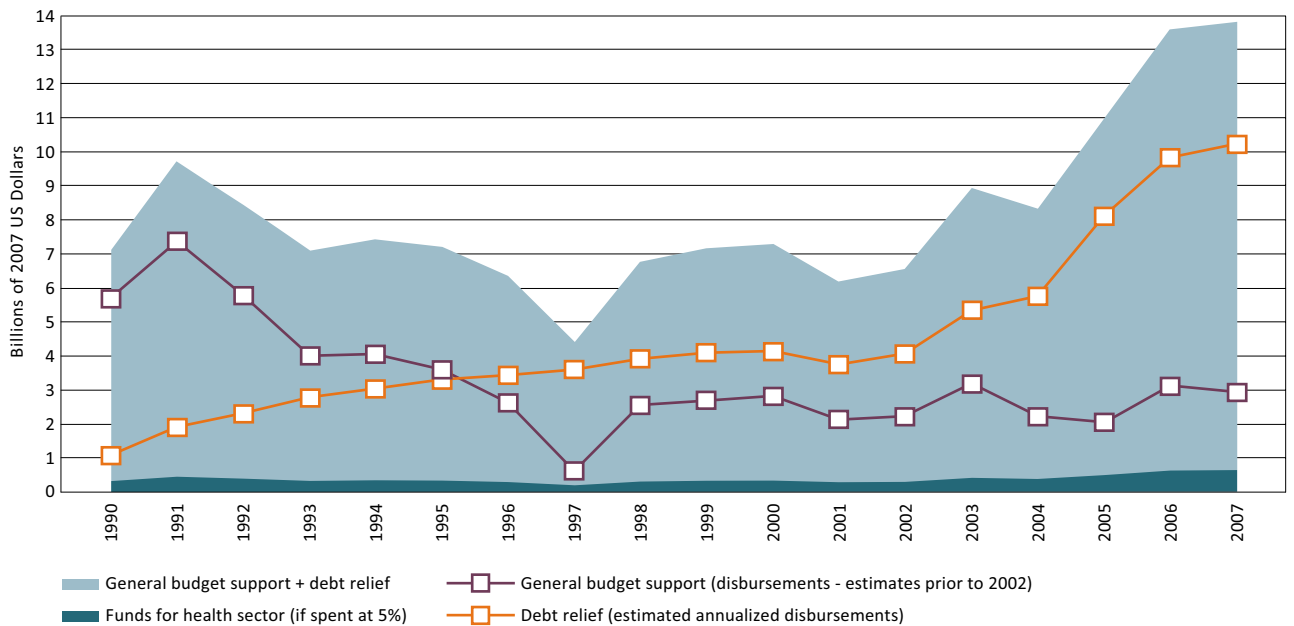
This figure shows annual commitments and not disbursements. Sector-allocable ODA excludes general budget support, debt relief, and humanitarian assistance.



Source: OECD-DAC Creditor Reporting System

**FIGURE 13**

**General budget support and debt relief from the 22 DAC donor countries and the EC**



Source: OECD-DAC Creditor Reporting System