

CHAPTER 4:

SOURCES OF DEVELOPMENT ASSISTANCE FOR HEALTH

The rapid-growth phase, in addition to concentrating on certain health focus areas, was characterized by the emergence of new sources of DAH as well as large increases in DAH from traditional sources. This chapter explores the variation in sources of DAH over time up until 2010 (the most recent year for which estimates are available). The peak of DAH in 2010 coincides with growth in DAH for most sources, although several prominent bilateral actors reduced spending from 2009 to 2010.

In the more recent no-growth phase, development assistance has come under increased pressure due to the lackluster economic recovery and the consequent

adoption of austerity measures in OECD countries. Among the top 15 donors, eight expected development assistance to drop in 2012.⁷ However, the UK and Australia, in addition to several other OECD countries, remained committed to their development assistance targets.⁷ The OECD’s Development Assistance Committee (OECD-DAC) bilateral aid is projected to grow only 1.3% in 2013, a significant slowing relative to the rapid- and moderate-growth phases.⁴⁰

Sources of DAH

In 2010, DAH reached a peak of \$28.2 billion as part of a historic high in ODA, which climbed to \$148.4 billion.¹⁹

FIGURE 27:
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 2012

Notes: 2011 and 2012 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 2011 and 2012.

The US was the single largest contributor to both ODA and DAH. In 2010, the US provided the second-highest real level of ODA ever recorded, at \$30.4 billion.⁴⁰ US DAH alone amounted to \$10 billion or 35.6% of total DAH, as represented by Figure 27 (on page 37). This was a 19.6% increase on 2009 spending.

The trends in European bilateral spending were mixed, reflecting the economic and political climate prevailing in Europe. While a number of bilateral agencies in fact increased their DAH, the pressure to slash budgets and the implementation of austerity measures were also observed. The UK provided the second highest level of DAH among sources in 2010 (\$2.3 billion), constituting 8.2% of the total, but decreased its spending relative to 2009 (17.2%). France also increased its DAH to \$1.17 billion, a 22% increase. Norway increased less than a half a percent to \$704 million. In contrast, Germany's DAH of \$947 million contracted 9.5% from 2009. The DAH provided by Spain (\$596 million) and the Netherlands (\$552 million) also shrank by 25.4% and 5.9%, respectively.

Outside of Europe, the other most prominent donors increased their DAH disbursements. In 2010, the DAH

provided by Japan amounted to \$867 million, a 17.2% increase on 2009. Canada's DAH in 2010 increased substantially (31.3%) to \$883 million. Australia's DAH (\$521 million) grew a significant 56.7% in 2010.

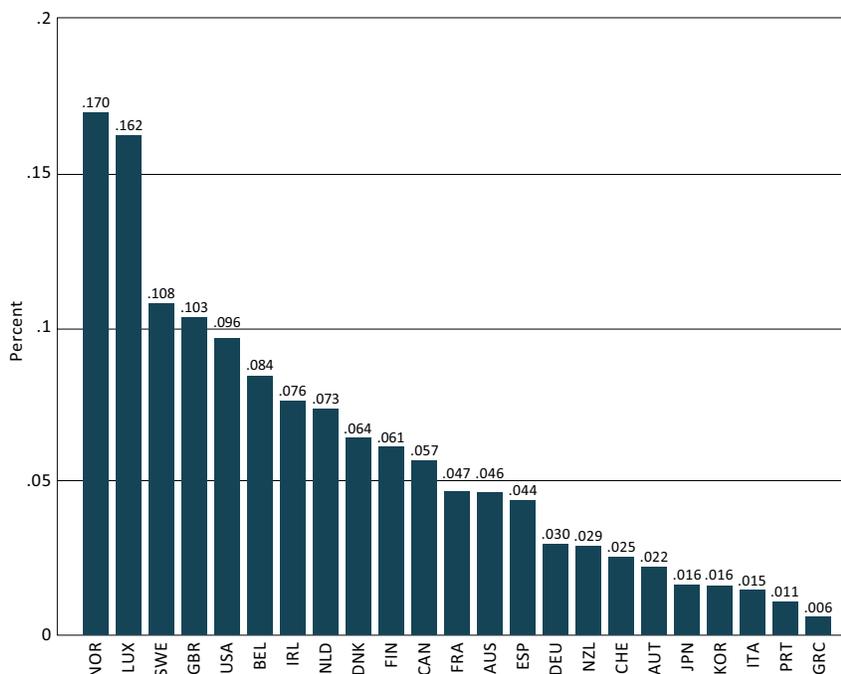
A solid majority of OECD countries increased their DAH disbursements from 2009 to 2010. However, looking to 2012 and beyond, projections of decreased ODA flows augur poorly for DAH. Japan's 2012 budget for ODA projected a 2% contraction in ODA.² Similarly, Canada and France announced their aid budget would shrink from 2012 to 2013.^{3,41} The Netherlands announced it would be spending \$1.2 billion less in ODA in 2012.⁷

A number of countries were also projected to increase ODA, an indication of the potential continuation of the no-growth phase of DAH. Australia anticipated that DAH would increase in 2012.⁴² The UK, while unable to spend as much as initially projected, also has committed to meeting its spending goals in coming years.⁴³ Norway announced a total of \$4.7 billion of ODA would be disbursed in 2012, a record high for Norway.^{44,45} Germany also announced that its 2012 budget would increase.⁴⁶

FIGURE 28:
DAH as a percentage of gross domestic product, 2010

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



Sources: IHME DAH Database 2012 and World Bank World Development Indicators

DAH as a share of GDP

In 2002, development assistance partners signed the Monterrey Consensus, which committed signees to contributing 0.7% of gross national product to development assistance.⁴⁷ Among OECD-DAC countries, only Denmark, Luxembourg, the Netherlands, Norway, and Sweden reached those targets in 2010.⁴⁸ Many other countries, however, have maintained their commitments to eventually attain that spending goal, notwithstanding the global financial crisis.⁷

DAH as a percentage of GDP was relatively stable from 2009 to 2010, as depicted in Figure 28. It is important to note that changes in total GDP influence this measure as much as fluctuations in DAH. As a percentage of GDP, Norway continues to top the list of donor countries, followed closely by Luxembourg. Norway's contribution to DAH as a percentage of GDP dropped from 0.186% in 2009 to 0.17% in 2010. Luxembourg gained in percent terms, rising from 0.144% to 0.162%. Sweden's support also decreased from 0.123% to 0.108% of GDP. Since 2009, these top three donors have remained constant, while small shifts occurred in the position of the other contributors. The US moved from fourth (0.091%) to

fifth (0.096%), while the UK moved up to fourth to 0.103% in 2010.

Public sector DAH

Among the different sources of public-sector DAH, countries favored different modes of delivery. Figure 29 illustrates that the US and Canada tended to provide relatively more funding to NGOs than European countries, which preferred to channel support through their bilateral agencies. The US provided 52.9% of DAH through NGOs while 48% of Canada's DAH also flowed through these organizations. Korea, on the other end of the spectrum, channeled 80.6% of DAH through governmental entities. Certain European countries even favored particular multilaterals. Relative to the other countries, Finland and Austria allocated a high proportion of DAH to UNFPA. France spent a relatively high proportion of its DAH supporting GFATM (35%). Germany, Japan, and Italy tended to favor a mix of bilateral and multilateral organizations.

Including all sources, 38.7% of DAH was channeled to NGOs, 25% flowed through governmental entities, and the remaining was split among UN agencies and other

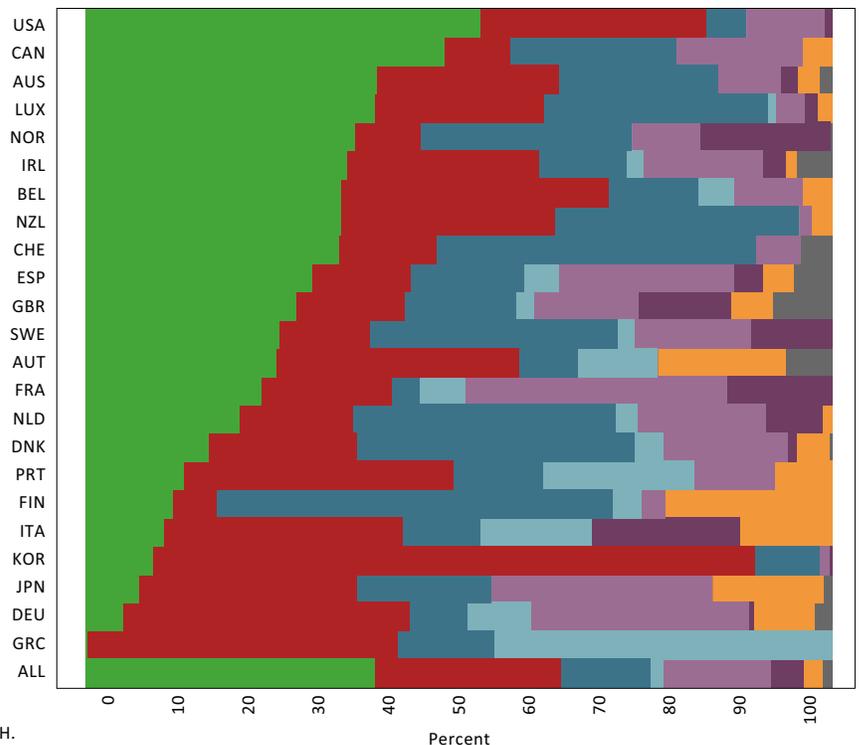
FIGURE 29:
Public sector DAH (donor-country-specific) by channel of assistance, 2010

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 = Netherlands
 - NOR = Norway
 - NZL = New Zealand
 - PRT = Portugal
 - SWE = Sweden
 - USA = United States
- Unspecified
 - World Bank – IDA
 - Global health partnerships:
 - GAVI
 - GFATM
 - United Nations and European Commission:
 - EC
 - UN agencies (WHO, UNICEF, UNAIDS, UNFPA)
 - Bilateral:
 - Governments
 - Non-governmental channels:
 - NGOs, PPPs, other

Source: IHME DAH Database 2012

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



multilaterals. A very small proportion was unspecified (1.3%). The high proportion of spending on NGOs overall was driven predominantly by the large amount of DAH provided by the US to NGOs.

NGO spending

The role of NGOs in the provision of DAH has become more prominent over the last two decades. NGOs increasingly contribute to improvements in health systems and the provision of health services the world over. The upsurge in DAH has, in fact, coincided with increased spending by NGOs. However, the trend picked up even earlier for NGOs. As Figure 30 shows, US NGO spending increased at a rapid pace from 1996 onward.

US NGOs were also hit hard by the financial crisis. After peaking at \$3.7 billion in 2009, spending by US NGOs dropped precipitously, decreasing approximately 20% from 2009 to 2010, according to IHME’s preliminary estimates. The decrease continued from 2010 to 2011 (11.1%), but some recovery was evident from 2011 to 2012, with growth of 4.3%. It must be noted that, due to more information coming to light, the 2009 and 2010 DAH totals for US NGOs have been refined. IHME

originally estimated the 2009 figure to amount to \$3.2 billion; given improved data, this has been adjusted to \$3.7 billion. The 2010 figure has also been changed from an original estimate of \$2.5 billion to \$2.96 billion in this year’s report. Over 2009 to 2010, NGOs disbursed more than initially expected on health.

The absolute drop from 2009 to 2012 occurred across revenue sources, but contributions from other public (i.e., government) and international organizations fell most significantly. However, in 2012, contributions to US NGOs from this category amounted to just 7.7% of total spending. BMGF contributions also fell significantly, although as noted, these tend to fluctuate as disbursements are often made in large installments. BMGF contributions amounted to 2.6% of US NGO spending in 2012. The most significant source of funding in 2012 was provided by US public sources (44%), followed by private financial contributions excluding BMGF (35.4%). Private in-kind donations, which consist of donation of medical supplies and pharmaceuticals, made up 10.3% of contributions to NGOs. All sources provided less DAH to NGOs in 2012 than at the NGO DAH peak in 2009.

FIGURE 30:
Total overseas health expenditure by US NGOs, 1990-2012

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

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

Source: IHME DAH Database (NGOs) 2012

*Data from 2010-2012 are based on preliminary estimates.

Notes: Data reflect US-based NGOs registered with USAID.

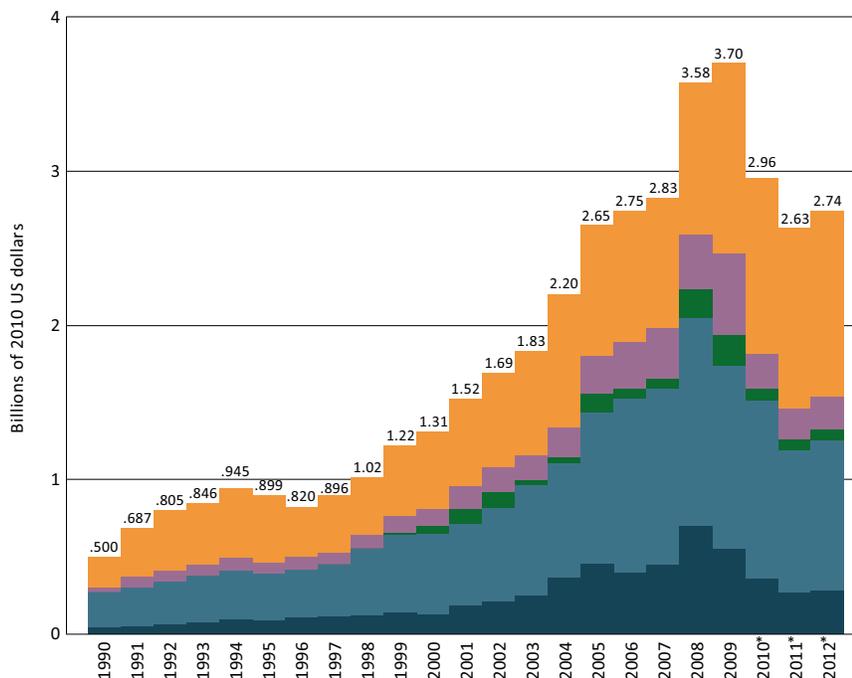


TABLE 2:
US-based NGOs with the highest cumulative overseas health expenditures, 2006-2009

Expenditures shown in millions of 2010 US dollars.

Rank	NGO	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	1,401.59	1,401.66	1,535.22	17	0
2	Catholic Relief Services	808.63	813.91	2,505.06	33	1
3	Food For The Poor	747.95	2,820.52	4,439.78	98	90
4	PATH	601.25	612.21	648.82	84	2
5	Management Sciences for Health	515.06	515.06	566.35	1	0
6	William J. Clinton Foundation	442.75	448.67	524.84	67	2
7	United Nations Foundation	380.54	404.21	507.78	92	7
8	Elizabeth Glaser Pediatric AIDS Foundation	356.92	358.25	376.96	16	0
9	CARE	305.47	306.26	2,465.63	26	0
10	Pathfinder International	303.33	303.33	341.56	21	0
11	Academy for Educational Development	286.03	287.79	1,172.50	12	1
12	MAP International	285.94	1,367.75	1,465.55	100	97
13	Save the Children	281.16	292.47	1,518.85	50	5
14	World Vision	280.48	380.64	3,413.35	76	32
15	Brother's Brother Foundation	252.49	1,345.25	1,941.37	100	99
16	International Medical Corps	246.52	364.45	388.71	50	40
17	Project HOPE	227.91	559.91	604.82	92	73
18	Catholic Medical Mission Board	204.39	846.72	871.97	100	93
19	Feed the Children	201.60	691.25	1,905.40	100	87
20	Population Council	184.64	194.65	264.13	37	6

Source: IHME DAH Database (NGOs) 2012

Notes: Overseas health expenditure for 2010-2012 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).

Table 2 displays the US NGOs with the highest cumulative overseas health expenditures, which varied little from that reported in last year's *Financing Global Health*. Population Services International topped both the 2012 and 2011 rankings. Catholic Relief Services, Food For The Poor, PATH, and Management Sciences for Health were all among the top five in the 2011 edition as well. However, International Medical Corps and Feed the Children joined the top 20 US NGOs list, while the Carter Center and ChildFund International dropped off for the 2006 to 2009 period.

Due to reporting limitations, IHME is only able to generate estimates for US-based NGOs. Our estimates of NGO expenditure are based on financial data

provided by a sample of the US-based NGOs that spend the greatest amount of money overseas. For the most part, US-based NGOs that do not appear in the data from USAID's annual *Report of Voluntary Agencies* were, unfortunately, also not included in our estimates. In contrast to many bilateral and multilateral organizations, most NGOs do not publish complete and standardized health expenditure data. IHME's research on health expenditure by NGOs would be strengthened if these data were reported systematically. In an encouraging development, many UK-based NGOs have begun reporting their financial data in line with the International Aid Transparency Initiative.