



CHAPTER 3:

PUBLIC DEVELOPMENT ASSISTANCE FOR HEALTH

As was mentioned in the previous chapter, donor country governments on average accounted for two-thirds of total development assistance for health (DAH) from 1990 to 2007. In this chapter, we take a closer look at these flows. At present, there is no integrated database for development assistance from all donor countries. The only comprehensive data source that exists for tracking public contributions is the Development Assistance Committee of the Organisation for Economic Co-operation and Development's (OECD-DAC) International Development Statistics that tracks aid from its 22 member countries.²⁰ However, the OECD-DAC restricts the type of aid contributions that member country governments can report. Hence, its estimates of public assistance for health from its member countries, which it measures in terms of official development assistance (ODA) for health, does not capture all publicly financed health aid. Below, we first discuss the differences in our approach to measuring health aid from public sources versus that employed by OECD-DAC. Next, we present an analysis of health aid from public sources using our estimates.

Comparing our approach and OECD-DAC's measure of official development assistance

There are two key differences between OECD-DAC's estimates of ODA for health and our approach to estimating public DAH.

The first relates to how funds flowing from donor governments to multilateral institutions are counted. OECD-DAC distinguishes between bilateral ODA and multilateral ODA. Bilateral ODA estimates include all aid going directly to recipient country governments, non-governmental organizations (NGOs), and multilateral institutions, *except* assessed contributions from donor governments to the regular budgets of multilateral institutions. Assessed contributions to multilateral institutions like the World Health Organization (WHO) and the World Bank are payments made against previous agreements or promises made by the donor governments. They do not count towards official bilateral aid because the donor countries lose effective control over how these funds are spent. In contrast, voluntary or extra-budgetary contributions from the donor governments to these same multilateral institutions count as bilateral ODA because the donor countries can stipulate how and where the funds are to be used.

OECD-DAC separately tracks multilateral ODA, which are the funds flowing from international institutions and agencies to developing countries. However, its coverage on this front is still limited. For example, its database does not reflect all of WHO's activities (it excludes all programs funded from the regular budget) and does not include Global Alliance for Vaccines and Immunization (GAVI) disbursements.

In contrast, our estimate of public DAH includes:

- All bilateral aid from the OECD-DAC’s database that is classified as being for the health sector, excluding all transfers – regular and voluntary – made to other channels of assistance tracked by the study. We take out these transfers to avoid double-counting.
- For each of the other channels besides the bilateral agencies, we calculate the amount of their health contributions that were publicly financed. For example, we disaggregate GAVI’s total giving by the fraction of its revenue that came from different income streams. We then count that portion of its total expenditure that can be attributed to a particular country government towards that country’s public contribution.

Hence, our estimates of public development assistance for health include both bilateral assistance as defined by OECD-DAC and the public-share of health assistance from all channels tracked by the study.

The second key difference between OECD-DAC’s health ODA estimates and public health aid estimates presented stems from the quantity of interest used to track aid. While OECD-DAC counts all commitments made in a year, we have estimated annual disbursements. Commitments on health loans and grants, which promise payments of specified amounts to the recipient over several years, do not reflect flows in the year they are made. For capturing the true time trends of global health resource flows, disbursements are the right quantity to track, although they are harder to find. One of the key contributions of this study is to estimate disbursements for missing years. The methods used are described in detail in the methods annex.

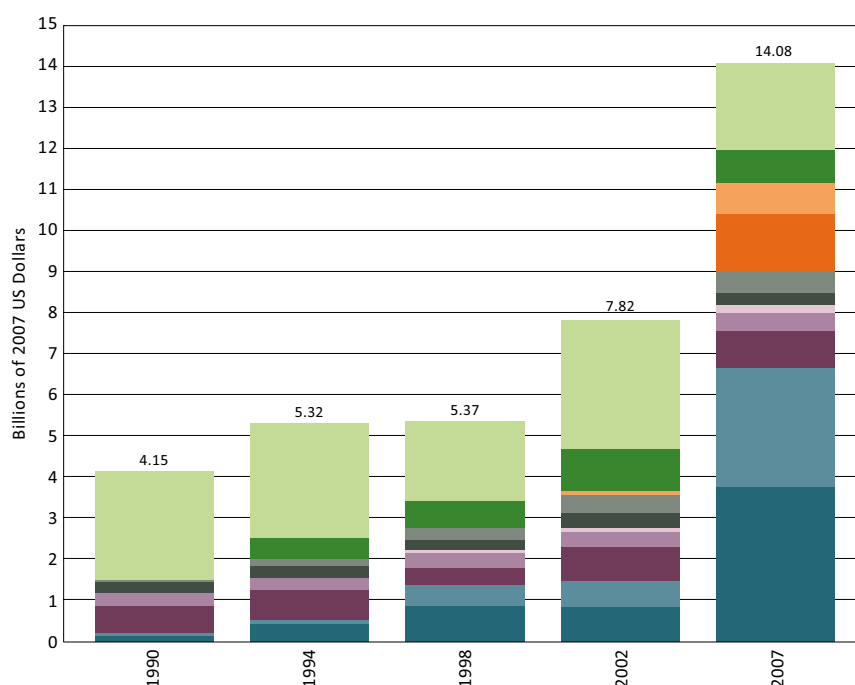
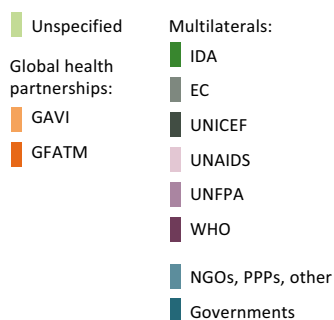
Public development assistance for health

Figure 14 shows total publicly financed health aid at four time periods from 1990 to 2007. The total volume of public DAH (measured in 2007 US\$) increased from \$4.2 billion in 1990 to \$14.1 billion in 2007. The figure also shows the composition of these funds by the

FIGURE 14

Publicly financed development assistance for health in 1990, 1994, 1998, 2002, and 2007

Bilateral assistance from the 22 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 shown here as “unspecified.”



Source: IHME DAH Database

channel of delivery through which they flowed. For the channels of assistance tracked in the study – United Nations (UN) agencies, the European Commission (EC), the International Development Association (IDA) (the arm of the World Bank that receives contributions from donor governments), GAVI, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) – the public-share of their health contributions is shown in the graph. In the case of bilateral health aid, the channel of delivery refers to the first recipient of the bilateral aid. The share of bilateral aid that flowed to developing country governments as well as NGOs, public-private partnerships (excluding GFATM and GAVI), and other civil society organizations (CSOs) are separately shown. Bilateral aid for which the OECD-DAC’s data did not include any information about the channel of delivery is marked as “unspecified.” It is worth noting that donor governments have improved the quality of the data they are reporting to the OECD-DAC, and, as a result, the share of publicly financed

health assistance for which we are unable to ascertain the mode of delivery has declined over time. However, further improvements are needed on this front.

The figure highlights the dramatic increase in funds flowing through GAVI, GFATM, NGOs, and other recipients of bilateral assistance. In contrast, funds flowing through the World Bank, EC, WHO, United Nations Children’s Fund (UNICEF), and other UN agencies have not expanded at the same pace. The privatization of public aid for health is illustrated by the growth of the NGO share. Given that the share flowing through unspecified channels has declined from 1990 to 2007, these trends need to be interpreted with some caution.

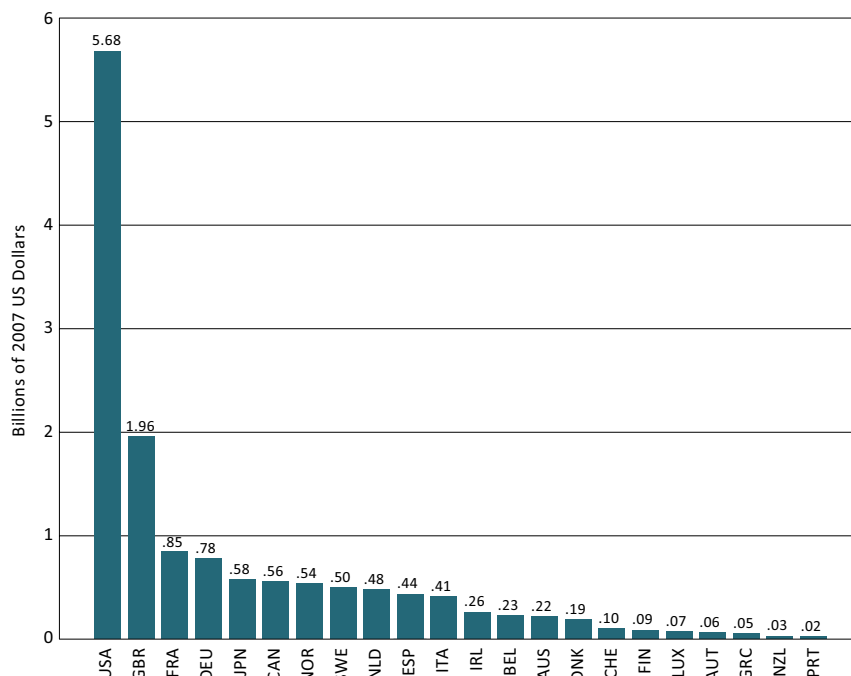
Comparing donors in 2007

Figure 15 shows the volume of public DAH from different donor countries in 2007. The US leads in the volume of aid, followed by the UK, France, Germany, Japan, and Canada. This comparison disregards total government expenditure in these donor countries. It

FIGURE 15
Publicly financed health assistance by donor in 2007

Public DAH from the 22 member countries of the OECD-DAC is shown.

- 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

has been often noted in the development assistance literature that while the US government contributes a large amount as development assistance, aid as a share of its total government size is small compared to other donor countries.

Figure 16 shows the composition of public monies by channel for each donor country in 2007. Countries in the figure are ordered by the fraction flowing directly to governments in developing countries. Some countries, specifically France, Italy, the Netherlands, and Finland have largely channeled their public monies through multilateral mechanisms. Other large donors such as the UK and the US have channeled a large fraction through bilateral mechanisms or through NGOs. The figure also illustrates the quality of the latest aid data available from OECD-DAC's systems. The fraction of "unspecified" aid corresponds to data reported by donors to OECD-DAC in which the channel of delivery variable is missing. In other words, these are projects

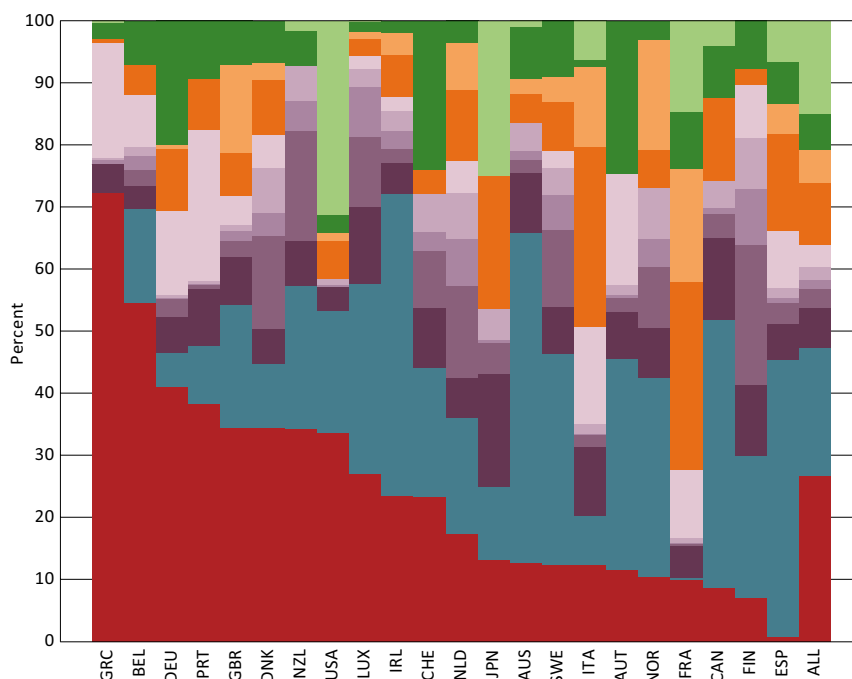
for which donors have failed to specify any principle recipient of the aid. The worst performer in this regard is the US. For over 30% of its public contributions towards health, we are unable to say whether the funds were going to developing country governments, US-based NGOs, international NGOs, or developing-country NGOs.

FIGURE 16
Channel-wise composition of publicly financed DAH by donor in 2007

The composition of DAH from the 22 member countries of the OECD-DAC is shown.

- | | |
|----------------------|-----------------------|
| AUS = Australia | GRC = Greece |
| AUT = Austria | IRL = Ireland |
| BEL = Belgium | ITA = Italy |
| CAN = Canada | JPN = Japan |
| CHE = Switzerland | LUX = Luxembourg |
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| ESP = Spain | NZL = New Zealand |
| FIN = Finland | PRT = Portugal |
| FRA = France | SWE = Sweden |
| GBR = United Kingdom | USA = United States |

- | | |
|-----------------------------|-----------------------|
| Unspecified | Multilaterals: |
| Global health partnerships: | IDA |
| GAVI | EC |
| GFATM | UNICEF |
| | UNAIDS |
| | UNFPA |
| | WHO |
| | NGOs, PPPs, other |
| | Recipient governments |



Source: IHME DAH Database