

DEVELOPMENT ASSISTANCE FOR HEALTH (DAH): RECENT TRENDS AND RESOURCE ALLOCATION

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This paper complements the CMH working paper “*Development Assistance for Health: Average Commitments 1997-1999*”. The first part reviews trends in development assistance for health (DAH) provided by bilateral and multilateral agencies; the European Community (EC); the Global Fund to fight AIDS, malaria and tuberculosis (GFATM); and grants provided by the Bill and Melinda Gates Foundation (BMGF). Together these sources provide an estimated ninety percent of total DAH. The second part presents a detailed analysis of geographic allocation of funds and for major components of interest, namely AIDS, malaria and tuberculosis. The last part discusses the major implications of key findings.

I. TRENDS IN DEVELOPMENT ASSISTANCE FOR HEALTH BETWEEN 1997 AND 2002

This period corresponds to a period of decline in overall ODA coupled with a new understanding of the importance of health as a major determinant of economic growth. Clear targets have been set as part of the Millennium Development Goals (MDG) to assess progress. The report of the CMH provided estimates of the substantial increase in DAH that would be needed to have a significant health impact. The first question therefore is “how far have we advanced towards a substantial increase in DAH”?

• Total ODA begins recovery in 2002

After a long period of decline in total official development assistance (ODA) during the past decade, the OECD reported a real increase of 5% in ODA provided by members countries of the OECD’s Development Assistance Committee (DAC) from 2001 to 2002. The total amounted to \$57 billion and hopefully signals the beginning of a recovery from the steady decrease of total ODA during the 1990s to an all time low in development assistance over the past three years. In 2002 total ODA increased from 0.22% to 0.23 % of combined gross national income (GNI). This is still far from the target of 0.7% of GNI set years ago.

Health ODA fared better than total ODA. The share of total bilateral ODA allocated to the health sector (including health and population) increased from 3.8 percent in 1990 (\$2.2 billion) to 6.8 percent in 2002 (\$2.9 billion). In spite of this steady increase,

bilateral health ODA had not quite caught up in 2002 with its peak value of \$3 billion in 1995.

• **Total development assistance for health (DAH) increased between 1998 and 2002**

Data sources

When assessing volume and trends of DAH, an important distinction has to be made between commitments and actual disbursements. Disbursements in a given year capture actual expenditures incurred that year, whereas commitments are usually made for a period of 3-5 years by most agencies. Typically there is a lag time between the time of commitment and actual disbursements of those funds. Unfortunately few agencies readily provide both commitments and disbursements. Most agencies included in this review provided commitments only, with the exception of UN agencies (WHO and UNICEF). The World Bank and more recently the GFATM track both components. Data sources and available datasets are provided below (Table 1).

TABLE 1: MAIN DATA SOURCES AND DATA TYPES

Funding sources	Data sources	Data type
Bilateral agencies	OECD: CRS and DAC (1)	Commitments
	USAID Congressional reports	Commitments
Multilateral agencies	WHO	Detailed expenditure reports
	UNICEF	Agency database
	World Bank	Agency database
	IADB	Agency database
	AfDB and AfDF	OECD: CRS
Other multilateral agencies	EC	Agency database
	GFATM	Data included in website
BMGF		Commitments and disbursements
		Data included in website
		Commitments

(1) The OECD provides data on the sectoral allocation of ODA for bilateral agencies only in DAC tables. The Creditor Reporting System (CRS) complements the DAC and captures detailed commitments to recipient countries. Reporting from bilateral agencies has improved overtime and is now almost complete. Commitments made by development banks have been and UN agencies have been added in recent years, with different levels of completeness.

This brief overview of available data sources points to a major shortcoming of current estimates, which is that they include a mix of commitments (for most agencies) and disbursements for WHO and UNICEF. The implications of this will be discussed in the third part of this report.

Key findings

Total DAH from major selected sources increased by \$1.7 billion - from \$6.4 billion on average between 1997-1999 to \$8.1 billion in 2002. Most of this increase was due to new funds committed by both public and private sources to the Global Fund to fight AIDS, tuberculosis and malaria (GFATM) (Table 2).

TABLE 2
RECENT TRENDS IN DEVELOPMENT ASSISTANCE FOR HEALTH (DAH)
SELECTED MAJOR SOURCES OF FUNDS
 USD (thousands)

	1997-1999 average	2002	2003
Bilateral agencies	2,559.8	2,875.2	
USAID	920.8	1,134.9	1,474.0
Multilateral agencies	3,401.5	4,649.2	
UN SYSTEM	1,575.5	2,036.3	
WHO	864.2	1,140.5	
Regular Budget	406.1	461.1	
Extrabudg. Contributions	458.1	776.5	
PAHO (own funds)	84.3	93.4	
UNAIDS	58.2	91.9	
UNICEF	275.8	391.0	
UNFPA	293.0	319.5	
DEVELOPMENT BANKS	1,522.0	1,405.5	
World Bank	1,124.9	983.0	1,171.8
IDA	713.5	536.4	586.2
IBRD	411.4	446.6	585.5
IADB	245.7	205.0	0.0
ADB (1)	287.7		
AfDB	151.4	217.5	
OTHER MULTILATERAL	304.1	1,207.4	
EC	304.1	244.5	
GFTHMT	0.0	962.8	979.2
Private non-profit			
BMGF	458.0	595.9	
Total DAH	6,419.3	8,120.3	

(1) Was not included in totals (pending update) to increase comparability of total DAH

Bilateral commitments increased only slightly over the past five years from 2.6 to 2.9 billion, and have not yet reached peak commitments made in 1995. Trends have varied in individual agencies. The most significant increase in commitments was made by the United States from \$920 million for the period 97-99 to \$1.5 billion in 2003. These amounts do not include an additional \$300 million committed to the GFATM and other multilateral agencies (Table 3)

TABLE 3
RECENT TRENDS IN DEVELOPMENT ASSISTANCE FOR HEALTH (DAH)
BILATERAL AGENCIES
 USD (thousands)

Bilateral agencies	1997-1999 average	2002	% total
United States	920.8	1,134.9	39.5%
United Kingdom	286.3	318.2	11.1%
Japan	359.9	308.5	10.7%
Norway	56.4	147.2	5.1%
Netherlands	101.4	136.9	4.8%
Germany	184.3	122.5	4.3%
France	128.4	111.8	3.9%
Sweden	79.1	104.5	3.6%
Australia	79.6	97.0	3.4%
Canada	28.7	88.4	3.1%
Belgium	60.5	68.4	2.4%
Spain	74.8	67.7	2.4%
Denmark	49.0	40.1	1.4%
Switzerland	17.9	31.2	1.1%
Italy	21.6	27.5	1.0%
Ireland	10.4	25.7	0.9%
Finland	17.2	23.8	0.8%
Portugal	8.7	7.8	0.3%
Greece	5.8	5.5	0.2%
New Zealand	3.3	4.2	0.1%
Austria	49.0	3.5	0.1%
Luxembourg	16.7		0.0%
Total	2,559.8	2,875.2	

UN agencies increased funding from 1.6 to 2 billion since 1997. The most notable was the increase in WHO extrabudgetary contributions, which almost doubled over the past five years – from \$460 million to \$780 million.

The rapid increase in IDA and IBRD commitments made by the World Bank during the 1990s has now stabilized around 1 billion per year.

The Gates Foundation, which increased rapidly since it was established in 1994 to \$460 million on average between 1997 and 1999, and \$ 600 million in 2002. Cumulative commitments since inception were equal to \$3 billion by October 2003.

• **The largest increase in funding was allocated to fighting AIDS in SSA**

Most major funding sources in the public and private sectors increased funding for HIV/AIDS, particularly in SSA (Table 4)

TABLE 4
RECENT TRENDS IN DEVELOPMENT ASSISTANCE FOR HEALTH (DAH)
FOR HIV/AIDS - SELECTED MAJOR SOURCES OF FUNDS
 USD (millions)

	1997-1999 average		2002	
	SSA	Total	SSA	Total
USAID	55.1	91.3	103.4	300.5
World Bank				
IDA	5.0	144.4	285.8	314.6
IBRD				20.9
BMGF			60.9	81.5
Sub-total	60.1	235.7	450.1	696.6

The Global Fund to fight AIDS, tuberculosis and malaria allocated 56 percent of total commitments to HIV/AIDS; 27 percent to malaria; and 15 percent to tuberculosis. The largest share of funds was allocated to SSA. Amounts actually disbursed so far are modest (\$150 million by September 2003) but are projected to increase rapidly. The estimated total amount committed in the first three rounds of proposals would lead to funding increasing by approximately 1 billion each year – or a cumulative budget of 1 billion the first year to reach 5.1 billion the fifth year.

The United States was the largest donor for HIV/AIDS in 2002. It committed \$790 million for HIV/AIDS. This was \$475 million more than the next largest donor and 50 percent of all amounts budgeted by all donors (US at G8 2003). The USAID HIV/AIDS budget in Africa increased from \$55 million on average in 97-99 to 193.4 million in 2002 (63 percent of total for HIV/AIDS). Uganda, Zambia and Kenya were the largest recipients of USAID commitments (\$20 million; \$18.5 million; and \$17.2 million respectively).

According to the Creditor Reporting System (CRS) on-line database, commitments from all other bilateral donors increased from \$205.3 (period average 97-99) to \$294.5 in 2001. The UK was the next largest donor and committed \$157.9 million in 2001.

UNICEF increased funding for HIV/AIDS in recent years to 9% of its total budget in 2002 (Annual Report 2002).

• Funds provided to RBM more than double WHO funds for malaria in SSA

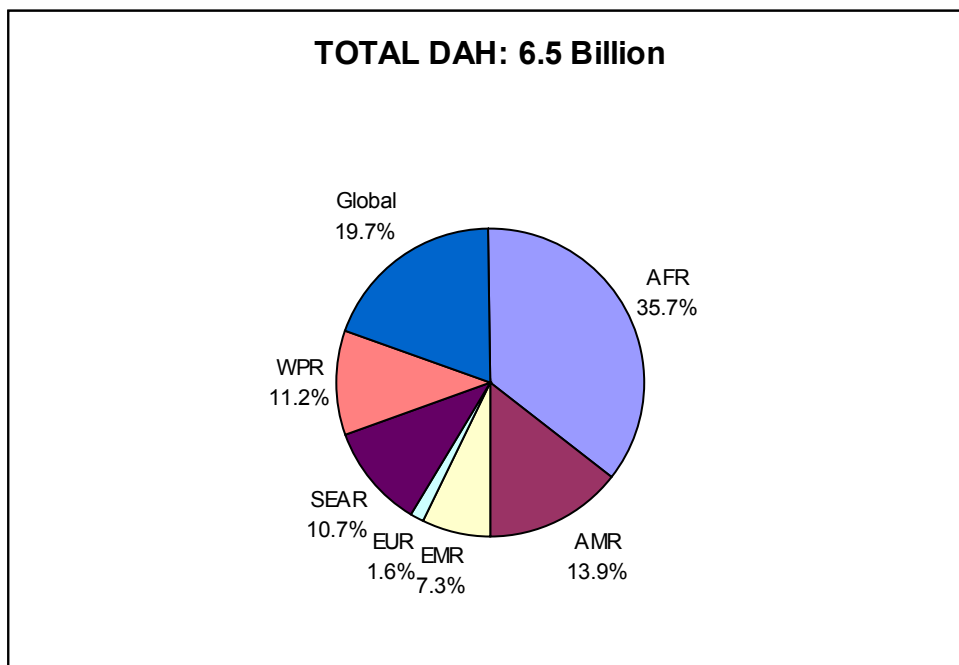
The partnership to roll back malaria (RBM) more than doubled total funding provided by WHO for malaria in SSA. It added \$6.4 million to the \$2.5 million allocated to malaria by other funds in 2002.

II. ALLOCATION OF DAH BY REGION AND MAJOR COMPONENTS IN 2002

Bilateral agencies, WHO, UNICEF, the AfDB/AfDF, the IADB, the World Bank, the EC, GFATM, and the BMGF provided detailed information on the allocation of ODH to recipient countries and major components of particular interest, namely HIV/AIDS, tuberculosis and malaria, and were included in this analysis. Together these agencies provided \$6.5 billion in 2002.

The largest share of funds was allocated to support country and regional activities (\$5.2 billion). The remainder (\$1.3 billion) was allocated to inter-regional and global activities. Regions included in this analysis were the six main WHO regions – Africa (AFR); the Americas (AMR); Europe (EUR); Eastern Mediterranean (EMR); South-East Asia (SEA) and Western Pacific (WPR). More than one third of all funds (36 percent) were allocated to Africa; 22 percent to Asia (SEA and WPR); 14 percent for the Americas; 7 percent to EMR and less than 2 percent to Europe (Table 5).

TABLE 5
OVERALL DISTRIBUTION OF ODA - SELECTED MAJOR SOURCES 2002



SELECTED SOURCES: BILATERAL AGENCIES, WHO, UNICEF, WORLD BANK, IADB, AFDB/AFDF, GFATM, BMGF (*for which detail allocation was available*)

The \$1.25 billion allocated to HIV/AIDS, malaria and tuberculosis represented approximately one fifth of total DAH for the selected sources combined. The allocation of the remainder 80 percent would of course be of great interest as well, but was outside of the scope defined for this study. The largest share was allocated to HIV/AIDS (14 percent) and approximately 3 percent to both malaria and tuberculosis.

The allocation for each component, however, varied significantly between regions. The largest share for HIV/AIDS (56 percent) and for malaria (69 percent) were allocated to Africa, and the largest for tuberculosis to the Western Pacific (62 percent) (Table 6).

TABLE 6
DISTRIBUTION OF ODA MAJOR COMPONENTS - SELECTED MAJOR SOURCES 2002
 USD (thousands)

	Total DAH	SUB-TOTAL (AIDS, malaria, tuberculosis HIV/AIDS)			MALARIA	TUBERCULOSIS
TOTAL REGIONAL FUNDING	5,183,497	1,072,736	752,421	140,398	179,918	
AFR	2,292,677	550,892	417,545	96,658	36,689	
AMR	895,970	111,389	88,685	10,703	12,000	
EMR	466,096	13,499	5,551	7,541	407	
EUR	101,719	117,139	107,026	1,698	8,415	
SEAR	684,631	77,899	57,816	9,223	10,860	
WPR	717,060	190,619	64,548	14,524	111,547	
Global	1,266,959	11,249	11,249			
GLOBAL FUNDING	1,266,959	126,298	79,684	17,790	28,824	
TOTAL	6,450,457	1,247,738	879,607	158,187	209,944	

Percent Distribution

	Total DAH	SUB-TOTAL (AIDS, malaria, tuberculosis HIV/AIDS)			MALARIA	TUBERCULOSIS
TOTAL REGIONAL FUNDING	5,183,497	20.7%	14.5%	2.7%	3.5%	
AFR	2,292,677	51.4%	55.5%	68.8%	20.4%	
AMR	895,970	10.4%	11.8%	7.6%	6.7%	
EMR	466,096	1.3%	0.7%	5.4%	0.2%	
EUR	101,719	12.0%	15.7%	1.4%	4.7%	
SEAR	684,631	7.3%	7.7%	6.6%	6.0%	
WPR	717,060	17.8%	8.6%	10.3%	62.0%	
GLOBAL FUNDING	1,266,959	10.0%	6.3%	1.4%	2.3%	
TOTAL	6,450,457	19.3%	13.6%	2.5%	3.3%	

DAH per capita was equal to \$ 3.3 in Africa; \$ 0.8 in the Americas and \$ 0,77 in the Eastern Mediterranean region; \$ 0.41 in South East Asia and the Western Pacific regions.

Finally the allocation of DAH per capita varied by country within regions (Table 7 and Table 8. The ten countries that received the largest DAH per capita from all sources combined were in Africa (7 countries) and in the Americas (3 countries).

TABLE 7
TOP TEN COUNTRIES RECEIVING MOST DAH FROM SELECTED MAJOR SOURCES 2002
(1)

WHO region	population	Country Name	DAH per capita		DAH HIV/AIDS	DAH Malaria total	DAH Tuberculosis total
			USD	DAH total (000s)			
AMR	6,154	El Salvador	28.0	172,187	500	0	250
AFR	8,976	Zambia	16.7	150,222	25,933	5,978	27
AFR	1,695	Namibia	12.7	21,445	4,287	41	15
AFR	1,268	Gambia	12.2	15,488	47	57	6
AMR	2,560	Jamaica	11.9	30,368	12,728	0	4,009
AFR	9,240	Senegal	11.7	107,986	6,001	2,726	1,000
AMR	6,316	Honduras	9.6	60,820	3,888	220	650
AFR	5,937	Benin	7.3	43,250	2,861	1,564	3
AFR	6,565	Burundi	7.0	45,902	189	437	2,019
AFR	2,108	Leshoto	6.6	13,926	1,239	0	0

(1) Countries with a total population of less than 1 million were not included

**TABLE 8
TOP FIVE COUNTRIES RECEIVING MOST DAH FROM SELECTED MAJOR SOURCES 2002,
BY REGION**

WHO region	Population (000s)	Country Name	DAH per capita USD	DAH total (000s)	DAH HIV/AIDS	DAH Malaria total	DAH Tuberculosis total
AFR	8,976	Zambia	16.7	150,222	25,933	5,978	27
AFR	1,695	Namibia	12.7	21,445	4,287	41	15
AFR	1,268	Gambia	12.2	15,488	47	57	6
AFR	9,240	Senegal	11.7	107,986	6,001	2,726	1,000
AFR	5,937	Benin	7.3	43,250	2,861	1,564	3
AMR	6,154	El Salvador	28.0	172,187	500	0	250
AMR	2,560	Jamaica	11.9	30,368	12,728	0	4,009
AMR	6,316	Honduras	9.6	60,820	3,888	220	650
AMR	8,142	Bolivia	6.4	52,362	4,496	600	831
AMR	4,938	Nicaragua	6.0	29,496	674	0	0
EMR	27,867	Morocco	4.7	129,734	53	0	130
EMR	17,488	Yemen	2.6	45,037	138	247	27
EMR	21,923	Afghanistan	1.8	39,709	0	371	1,403
EMR	9,672	Somalia	1.8	17,475	0	90	191
EMR	3,236	Lebanon	1.3	4,279	297	0	20
EUR	3,839	Bosnia Herzaegovina	1.9	7,388	0	0	0
EUR	4,669	Kyrgystan	1.9	8,921	650	10	19
EUR	3,133	Albania	1.1	3,384	1,422	0	0
EUR	5,006	Georgia	0.7	3,275	1,100	10	2,417
EUR	23,942	Uzbekistan	0.6	14,377	4,009	0	2,365
SEAR	2,064	Bhutan	6.0	12,405	112	51	493
SEAR	28,385	Nepal	1.5	41,708	7,452	699	1,285
SEAR	18,639	Sri Lanka	0.7	13,087	51	5,287	2,890
SEAR	126,947	Bangladesh	0.6	80,779	3,452	0	600
SEAR	45,059	Myanmar	0.6	28,123	228	260	188
WPR	4702	Papua New Guinea	3.8	17821	0	171	149
WPR	5297	Lao People's Democratic Republic	3.4	17988	577	37	5
WPR	10945	Cambodia	2.7	29866	12531	1360	213
WPR	74454	Philippines	1.9	139960	2001	2915	2485
WPR	78705	Viet Nam	1.6	129165	32734	279	74

III. IMPLICATIONS OF KEY FINDINGS

The analysis of recent trends and allocation of DAH from major donors conveys mixed messages.

- There is no doubt that DAH fared much better than other sectors during the 1990s, maintaining a relatively steady level at a time when total ODA plummeted;
- The geographic allocation of DAH from all sources has been responsive to real needs, at least for HIV/AIDS, malaria and tuberculosis;
- The report of the CMH has led to the development of the Global Fund to fight HIV/AIDS, malaria and tuberculosis, and sparked increased commitment towards tackling major health problems in several developing countries;
- The allocation of funds – mostly commitments – increased by \$1.7 billion over the past five years;
- Political commitment is much higher than ever before: the President of the United States made the commitment to provide \$15 billion over the next five years to fourteen countries plagued by AIDS in Africa and the Caribbean (Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia).
- Yet, recent increases in DAH, although encouraging, fall short of meeting real needs.

It appears that things are moving in the right direction, although may be not quite as fast as would have been desirable. Are they really? Should the message provided at the end of the CMH follow up meeting be that all that is needed is to keep going and increase funding levels?

One major shortcoming of the analysis presented in this paper is that it combined commitments and disbursements as though they were comparable. They really are not, and this points to a fundamental issue, which is the pace at which funds committed are being disbursed. An increase in total disbursements of \$1.7 billion would have a totally different meaning than the same increase in commitments. It means that it will take several years before committed funds will actually be spent, and thus represents a much smaller increase in DAH than first appears.

This very issue lies at the core of the current difficulties encountered by the GFATM in receiving pledges needed to ensure sufficient funds in the future. The decision made just a little over a week ago by trustees of the GFATM to reduce the number of yearly funding cycles in order to ensure that the funds would not run out before projects funded in the first three rounds have been completed raises real concerns.

One key question that would be well worth discussing during this meeting, is the extent to which substantial increases in funds committed to countries in greatest need can be absorbed at the country level. It is quite striking that even though pledges reached 2 billion, only \$ 150 million dollars has actually been disbursed to countries, two years after the GFTM was established. What are major limiting factors to a more rapid disbursements of funds? Is the lag time between commitments and disbursements increasing with increased commitments – or is it decreasing ? What are the major limiting factors , and what could be done to address those?

There is no doubt that all stakeholders need to work much more closely together to identify and overcome major roadblocks to scaling up investments to improve health among the poor, as was recommended by the CMH.

