

HEALTH FINANCING: UNPACKING TRENDS IN ODA FOR HEALTH

CROSS-EUROPEAN ANALYSIS



Introduction

In the run-up to the Third Financing for Development Conference in Addis Ababa in July 2015, European donors must play a leading role in the international debate on the future of development assistance. Ongoing negotiations indicate growing support for domestic resource mobilisation as well as increases in international and domestic private finance.

This emphasis has the risk of marginalising the importance of Official Development Assistance (ODA). Within ODA reported to the Organisation for Economic Cooperation and Development (OECD)-Development Assistance Committee (DAC), non-grant transfers such as loans and equity investments are gaining in importance. Several European donors have started disbursing small but increasing amounts of health ODA, in the form of these 'new' aid mechanisms in past years.

Against this background, tracking how donors fund the health sector remains as important as ever. This is especially true as donors have a unique chance to renew their commitment to providing 0.7% of Gross National Income (GNI) to ODA, in the context of financing the implementation of the Sustainable Development Goals (SDGs).

The recent re-commitment of European Union (EU) donors to collectively spend 0.7% of GNI on ODA within the time frame of the post-2015 agenda¹ was a first step in this regard, but insufficient if it is not accompanied by a concrete, verifiable and binding timetable for reaching the target. In addition, European governments should champion financing for health and set a joint EU commitment to reach the World Health Organisation (WHO)-recommended target of 0.1% of GNI for health ODA.²

This paper aims to complement the individual profiles of the six Action for Global Health (AfGH) European donor countries – France, Germany, Italy, the Netherlands, Spain and the United Kingdom (UK) – and the EU institutions.

It will analyse broader cross-European trends in ODA and health ODA in the context of a changing international development finance landscape. It will track European ODA against the 0.7% and 0.1% GNI targets. Furthermore, it will outline global trends in development assistance for health and analyse the composition and distribution of European health ODA. This is with regards to aid delivery mechanisms as well as priority regions by geography and income.



Plan / Alf Berg

Over the current decade, lower care costs for health systems and for families could save up to \$6 billion in treatment costs.

TERMINOLOGY

Total ODA: ODA reported by Member States to the OECD-DAC;

Real ODA: Aid transfers after deducting debt relief, imputed costs* for students from developing countries, costs for refugees in donor countries and administrative costs, but crucially including loans;

Real grant ODA: The aid actually transferred after deducting loans;

Health ODA real transfers: An estimation of health ODA based on a project-by-project review of multilateral and bilateral assistance (including general budget support – GBS);

Health ODA in the form of grants: Health ODA real transfers, excluding loans [hereafter referred to as health grants].

*An imputed cost is a cost that has occurred but is not initially shown or reported as a separate cost.

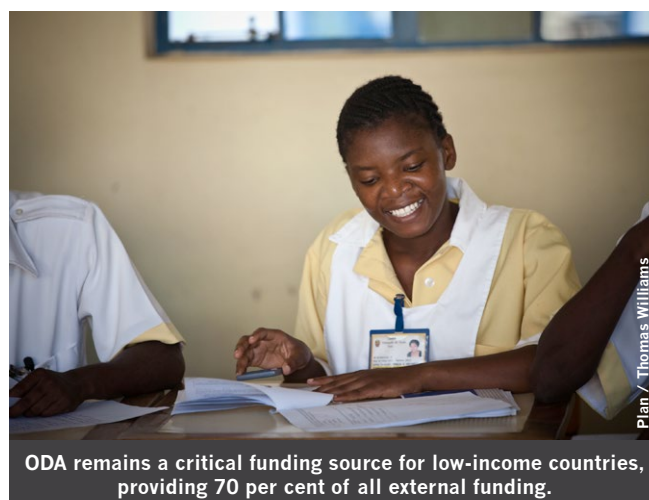
Methodology

The AfGH ODA analysis relies on official OECD-DAC figures for total ODA spending. The official figures only deduct the repayments of principal costs related to loans, whereas AfGH also deducts the repayment of interest. Net ODA figures may therefore differ from OECD-DAC figures.

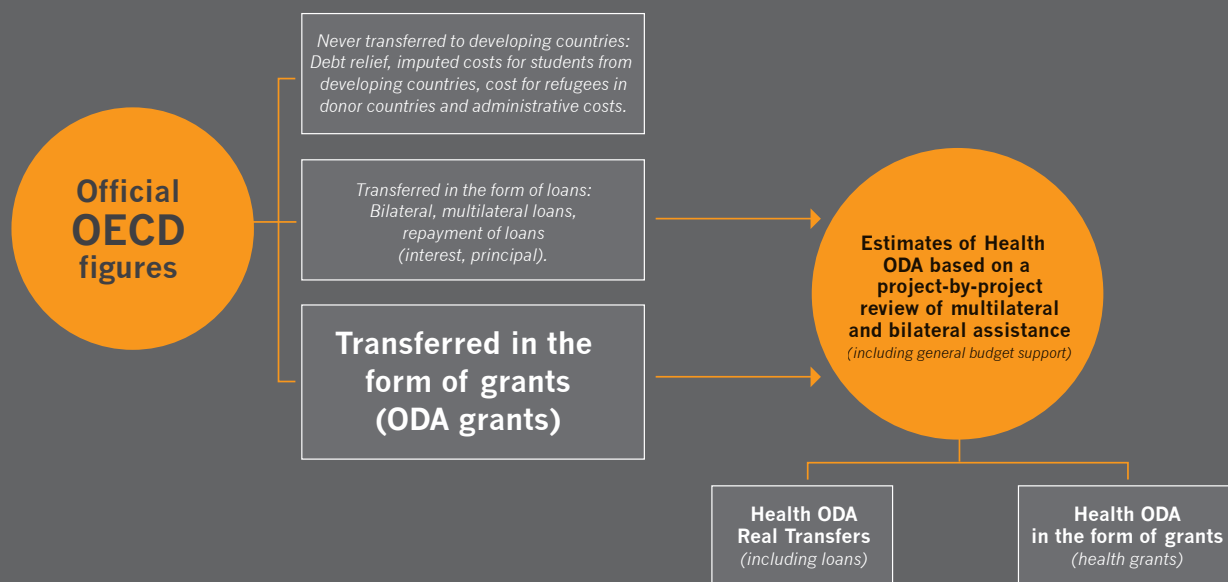
AfGH uses official OECD-DAC data up to 2013 (the latest data available) for the analysis of global and cross-European trends in health ODA. However, in the detailed country profiles, and for part of the cross-European analysis, AfGH uses a specific disaggregation method for the six European donors and the EU institutions. For a more in-depth analysis, AfGH further disaggregates public OECD-DAC figures of ODA disbursements.

Most health tracking relies on the bilateral flows reported by the health and population sectors of the OECD Creditor Reporting System (CRS) and OECD-DAC members' imputed multilateral contributions to the health sector. However, an AfGH/ Medical Mission Institute Würzburg (MMI) project-by-project review of donor projects and programmes analyses exactly what percentage of each goes to health. This research aims to correct the existing misclassifications and reporting errors made by the six donor countries and the EU institutions, as well as prevent double counting of certain multilateral contributions.

In addition, AfGH notes a greater use of large multi-sectoral and multi-country grants by OECD-DAC donors. This has led to a growing share of bilateral ODA, including health ODA, being reported as 'unallocated' or 'unspecified'. A better DAC coding system is necessary to improve transparency and donor accountability and more adequately reflect this new donor practice in the post-2015 framework.



METHODOLOGY VISUALISATION



Trends in Total ODA

Between 2013 and 2014, the group of EU OECD-DAC donors (including the EU institutions) slightly increased total ODA by 1% from US\$87 billion to US\$88 billion.³ This was the second consecutive increase since 2012 when EU ODA reached a five-year low of US\$85 billion. This was due to the austerity measures happening in several EU Member States.

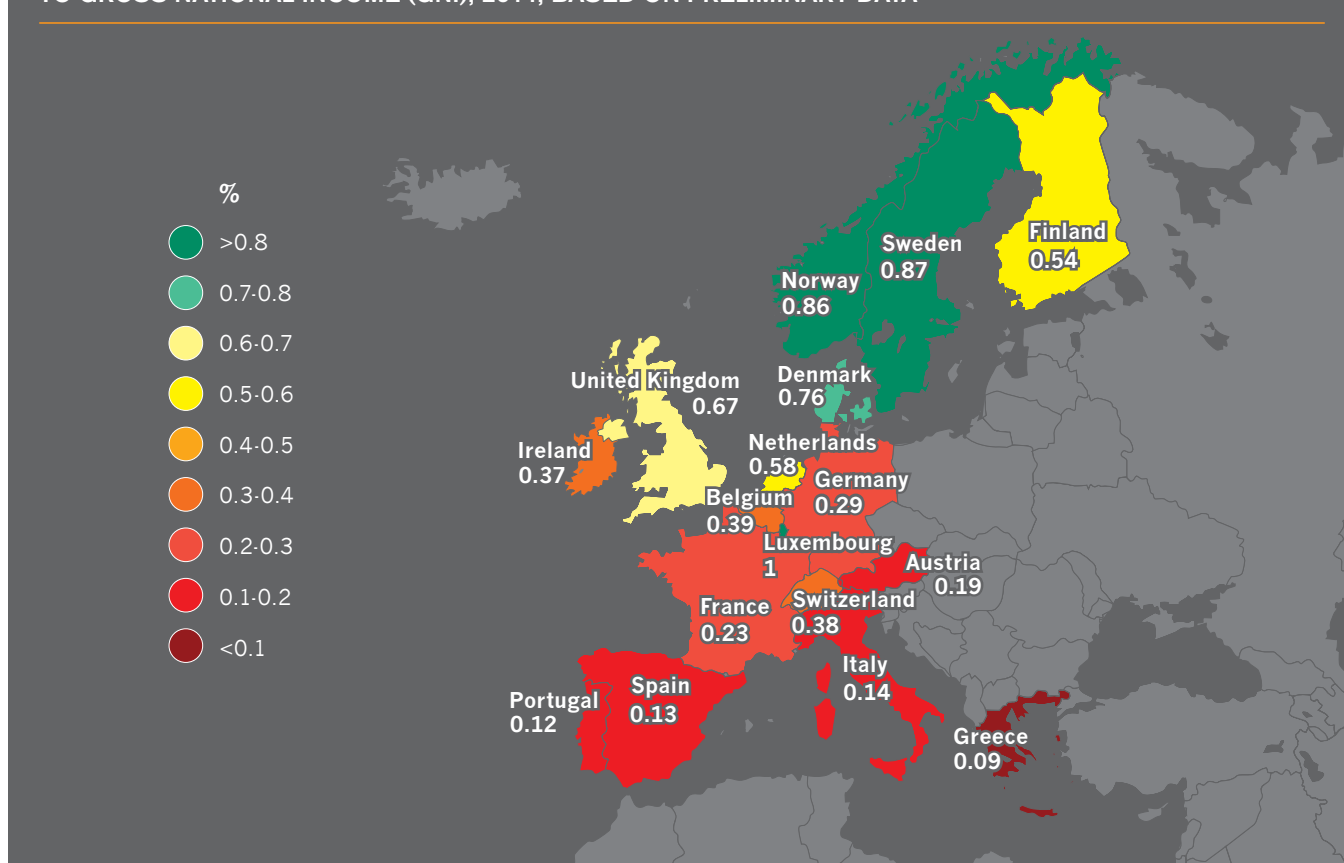
Ten individual EU OECD-DAC donors increased ODA in 2014, with Finland (+13%), Germany (+12%) and Sweden (+11%) as the front-runners in relative terms. By contrast, ten EU countries decreased development assistance in 2014, with the biggest relative cuts in Spain (-20%), Portugal (-15%) and Poland (-9%). This was despite the 2015 deadline for EU donors to increase ODA so as to collectively invest 0.7% of GNI in ODA.⁴ The three European OECD-DAC members that are not EU members delivered a mixed performance in 2014. Iceland and Norway decreased total ODA (both -4%), while Switzerland significantly increased aid (9%) to reach its individual target of 0.5% ODA/GNI by 2015.⁵

Despite the minor increase of ODA in terms of volume, only five European donors reached their international target of spending 0.7% of GNI on ODA in 2014.⁶ These were Denmark, Luxembourg, Norway, Sweden and the

UK. The Netherlands, historically a 0.7% champion, failed to meet the target for the second time in 2014.

However, when exclusively counting ODA grant transfers (see Figure 1), Luxembourg (1.02%), Sweden (0.87%), Norway (0.86%) and Denmark (0.76%), stand apart as the only donors to exceed the target. The UK, while being one of the largest donors in terms of volume, remains just below 0.7% (0.67%) when looking solely at grant transfers. The worst European performers with regards to the ratio of real transfers of grants to GNI in 2014 were those countries hardest hit by the economic crisis; Italy (0.14%), Spain (0.13%), Portugal (0.12%) and Greece (0.09%). Due to the growing share of loans in their ODA spending, Germany (0.29%) and France (0.22%) are also among the worst European performers, despite the fact they were Europe's largest donors in total ODA after the UK.

FIGURE 1: FINANCIAL EFFORT FOR DEVELOPMENT: TOTAL REAL TRANSFERS OF ODA GRANTS IN RELATION TO GROSS NATIONAL INCOME (GNI), 2014, BASED ON PRELIMINARY DATA⁷



Changing Aid Landscape

When looking at overall international financial flows, private flows to developing countries, including Foreign Direct Investment (FDI), were more than twice as high as ODA flows in 2013. Thus, these are an integral part of the global financing for development landscape.⁸

At the Third International Conference on Financing for Development in Addis Ababa in July 2015, much of the debate focuses on leveraging ODA as a catalyst towards even higher levels of international and domestic private financing, as well as domestic resources. In addition, the OECD-DAC is in the process of reforming its measurement system of ODA, and international public finance more broadly. This is to reflect the increased use of non-grant transfers by OECD-DAC donors such as loans, equity investments, and other non-ODA items reported to the OECD-DAC as 'other official flows'.

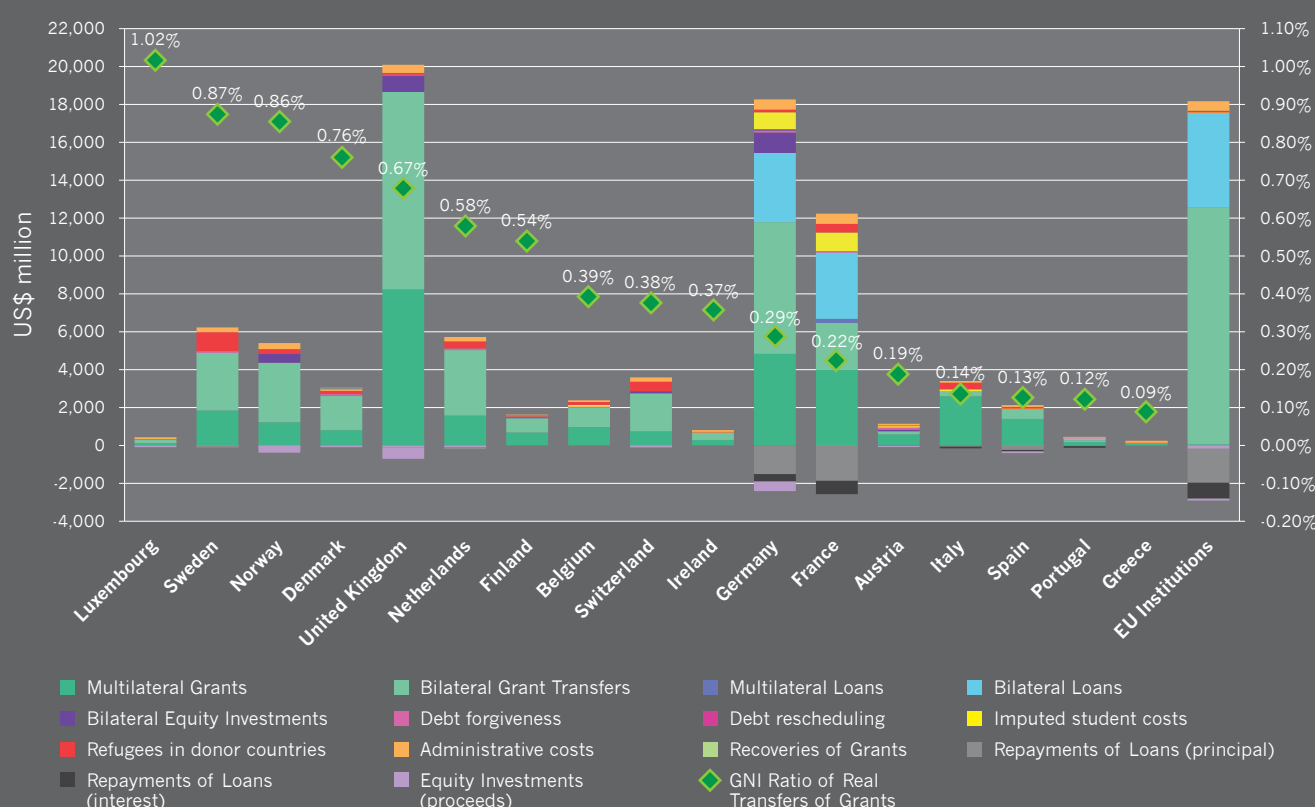
Considering Europe's role at the Financing for Development Conference, it is notable that non-grant ODA has gained in importance in EU ODA.⁹ In 2005, nearly all ODA provided by EU OECD-DAC donors (94%) was in the form of grants, while 6% was given as concessional loans. By 2013, the share of loans increased to 17% whereas the share of grants decreased to 81%.¹⁰ ODA equity investments, which were virtually

non-existent in 2005, increased to 2%. As Figure 2 showing the distribution of ODA in 2014 demonstrates, Germany and the UK are mainly responsible for this small but significant rise in equity investments.¹¹ The bigger share of bilateral loans can mostly be attributed to France, Germany and the EU institutions.

Within grant ODA, another European trend is emerging with debt relief becoming increasingly less significant (see Figure 2). As a share of EU ODA, debt relief decreased substantially from 32% in 2005 to 4% in 2013. Only Austria and Germany reported considerable amounts (exceeding US\$100 million) in 2014.

On the other hand, several donors reported rising levels of in-country refugee costs as ODA since 2005. These include Denmark, Germany (albeit to a lesser extent), Italy, the Netherlands, Norway, Sweden and Switzerland. The overall share in EU ODA rose from 2% to 4% in 2013.

FIGURE 2: EU OECD-DAC MEMBERS*, COMPONENT OF ODA IN VOLUME AND AS A PERCENTAGE OF GNI



* Members before 2013

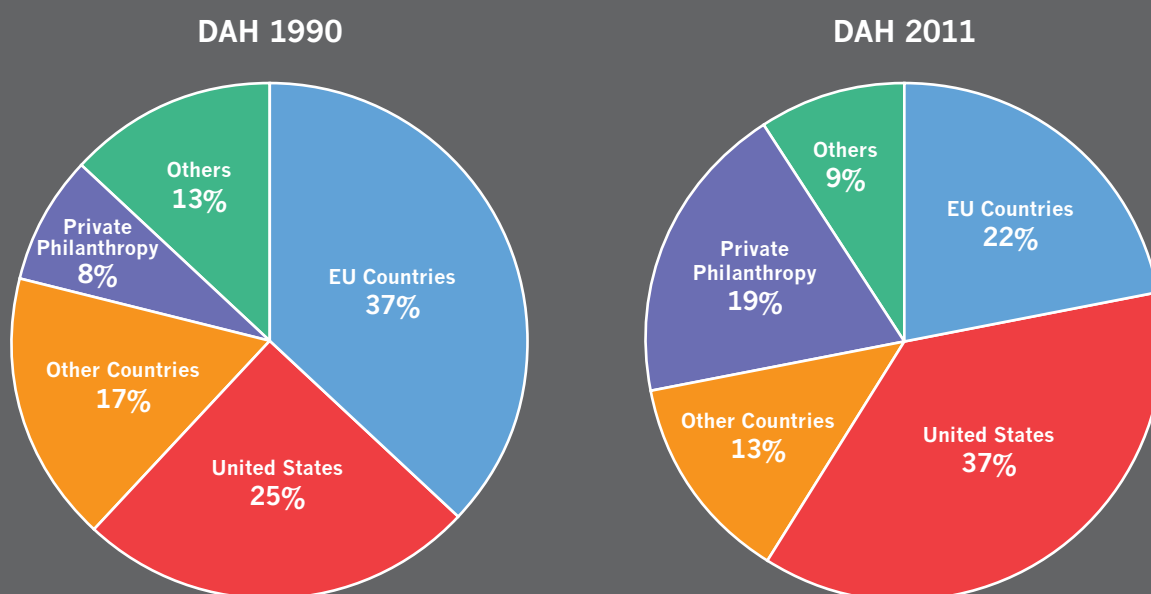
Health ODA Trends

To better understand European donors, it is necessary to see them in a changing funding landscape in terms of health ODA over a period of 25 years and, not least, in the context of the ongoing post-2015 'Financing for Development' process. Between 1990 and 2011, the increase in total global health ODA was about six-fold – with the most significant rise following the adoption of the Millennium Development Goals (MDGs) in 2000.

The donor landscape has changed significantly, as the United States (US) in particular has emerged as a major actor in global health. The US increased its share in Development Assistance for Health (known as DAH) from 25% in 1990 to 37% in 2011 (see Figure 3). International private flows, i.e. corporate donations, philanthropy and other private investments, have also

grown significantly, notably with the emergence of the Bill & Melinda Gates Foundation in the late 1990s. Private philanthropy represented 19% of DAH in 2011. This is almost the equivalent of the health ODA of all EU countries (22%). Their share fell by 14% in the period 1990-2011.¹²

FIGURE 3: RELATIVE SHARE OF DEVELOPMENT ASSISTANCE FOR HEALTH BY DONOR, 1990 AND 2011



EU countries are losing their leading role on Development Assistance for Health (DAH): from 36% in 1990 down to only 22% in 2011



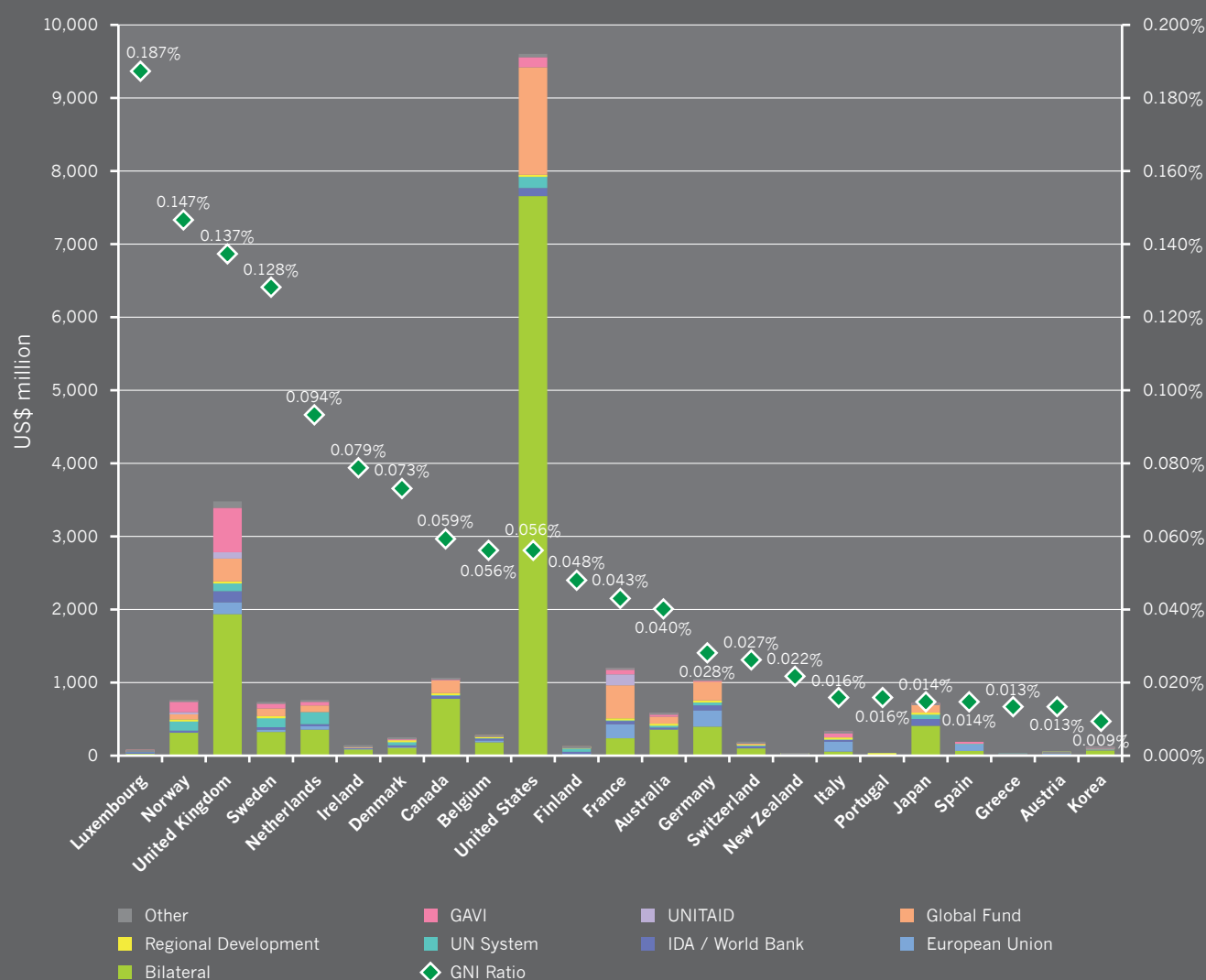
USA and private philanthropy increase their importance on Global Health

Figure 4 shows the US was by far the biggest public donor of ODA for health in 2013, with an investment of US\$9.6 billion. This is based on the latest available information on health ODA by OECD-DAC members (i.e. not taking into account private investments included in Figure 3).

In 2013, the UK (US\$3.5billion), France (US\$ 1.2 billion) and Germany (US\$ 1.1 billion) were the biggest European donors. But even their combined health ODA represented just 60% of US investment.

At US\$1.1 billion, Canada was the fifth largest health donor in 2013 investing levels similar to France and Germany. However, relative to the economic capacity of these top health donors, only the UK surpassed the recommended 0.1% of GNI in 2013. None of the other four exceeded a level of 0.06%, well below the recommended 0.1% target.

FIGURE 4: OECD-DAC MEMBERS: PRELIMINARY ESTIMATE OF ODA DISBURSEMENTS FOR HEALTH AND GNI RATIO IN 2013, BASED ON OFFICIAL OECD DATA FOR BILATERAL COOPERATION * AND OWN CALCULATIONS FOR THE HEALTH SHARE OF MULTILATERAL ORGANISATIONS



European progress towards the 0.1% Health ODA/GNI target

Only four European donors exceeded the target of 0.1% of GNI for health ODA in 2013; Luxembourg (0.187%), Norway (0.147%), the UK (0.137%) and Sweden (0.128%). The Netherlands (0.094%), Ireland (0.079%) and Denmark (0.073%) were close to reaching this target and have been amongst the top performers overall since 2007. Even in the global context, and in comparison to the group of OECD-DAC donors overall, these seven European countries stand out as the only donors to have made substantial efforts to reach the 0.1% target since the adoption of the MDGs in 2000.

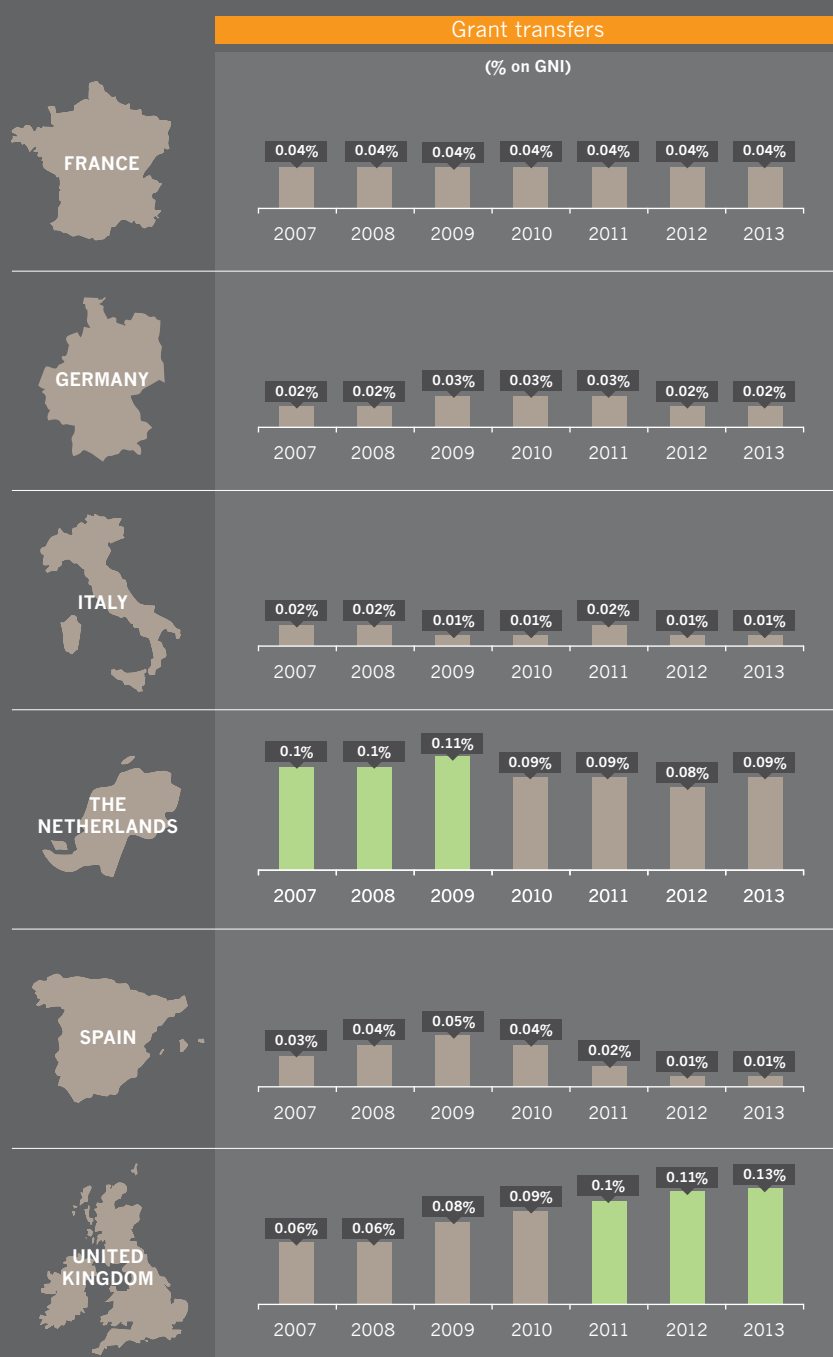
By contrast, France and Germany, Europe's biggest economies and G7 members, kept the ratio of health ODA to GNI at relatively low levels over time, reaching 0.043% and 0.028% respectively in 2013. Italy (0.016%) and Spain (0.014%) continued to feature among the worst European performers. Across

Europe, a significantly large group of donors did not exceed 0.06% in the period 2007-2013. These include important members of the EU-15 such as Austria, Belgium, Finland, France, Germany, Greece, Italy, Portugal and Spain.

US\$
10.7 billion

EU DAC members funding gap to reach 0.1% of GNI for Health ODA

**FIGURE 5: EUROPEAN OECD-DAC MEMBERS:
TREND OF ODA GRANTS FOR HEALTH IN RELATION TO GNI, 2007 TO 2012, PRELIMINARY DATA FOR 2013**



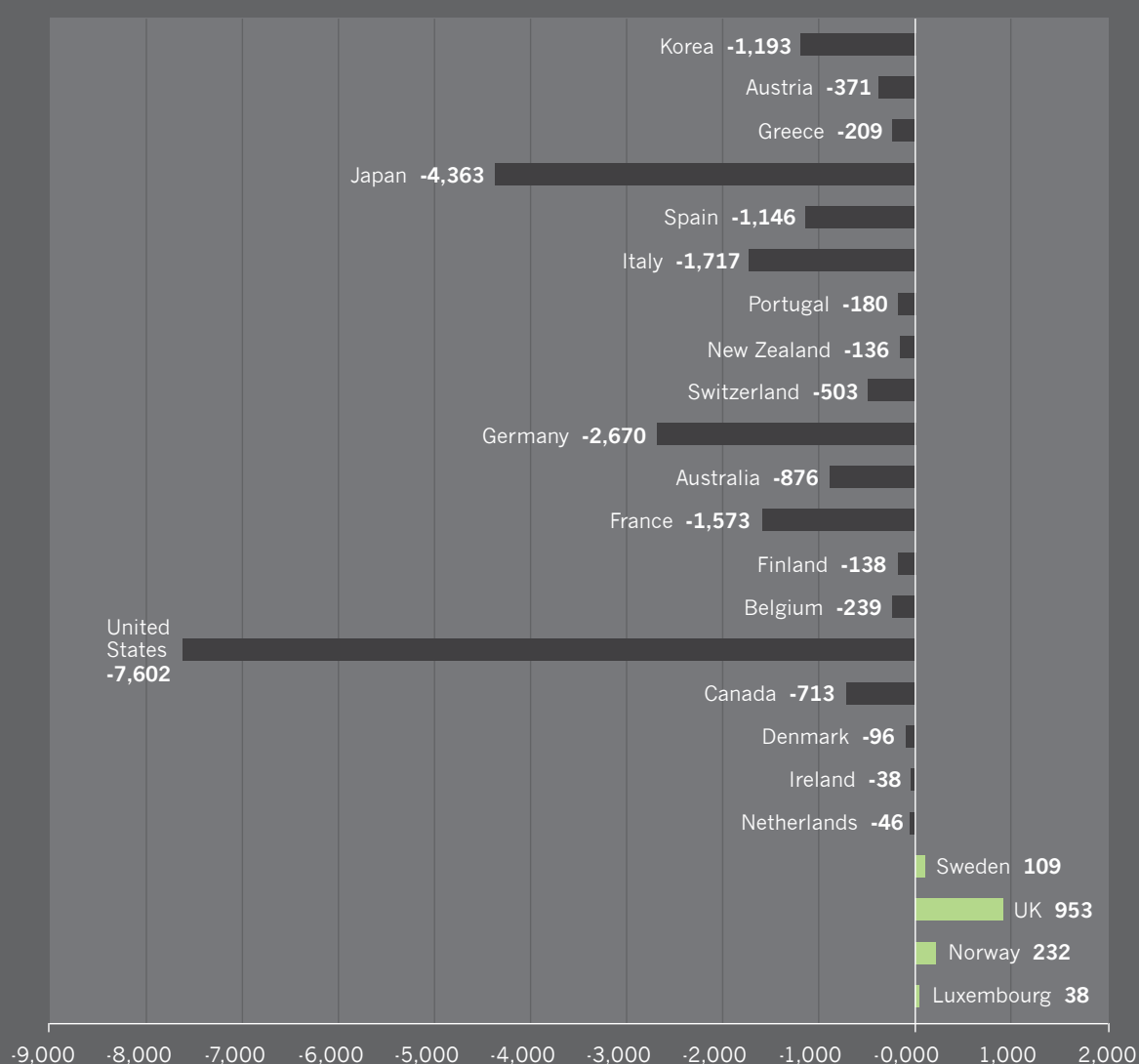
0.1%

0.1%

As a result of the poor overall performance of donors globally with regards to the health ODA target, in 2013 there was a resource gap in real transfers of US\$22.4 billion (see Figure 6). EU OECD-DAC members alone accounted for a gap of US\$10.7 billion, of which France, Germany, Italy and Spain accounted for US\$7.1 billion. These are the AfGH European donors furthest from the health ODA target.

The US and Japan stand out as the single biggest donors contributing to the total gap, with at US\$7.6 billion and US\$4.4 billion respectively for them to reach their individual 0.1% GNI targets.

FIGURE 6: GAP BETWEEN HEALTH ODA 2013 AND HEALTH ODA IF 0.1% TARGET REACHED



Composition of European Health ODA

Figure 7 shows the main components of health ODA provided by the six AfGH EU donor countries in 2013. Grants continued to be the preferred method of health ODA investment across all donors. The share of total health ODA varied between 100% (Netherlands and Spain) and 99% (Italy and the UK) on the one hand, and 93% (Germany) and 91% (France) on the other.

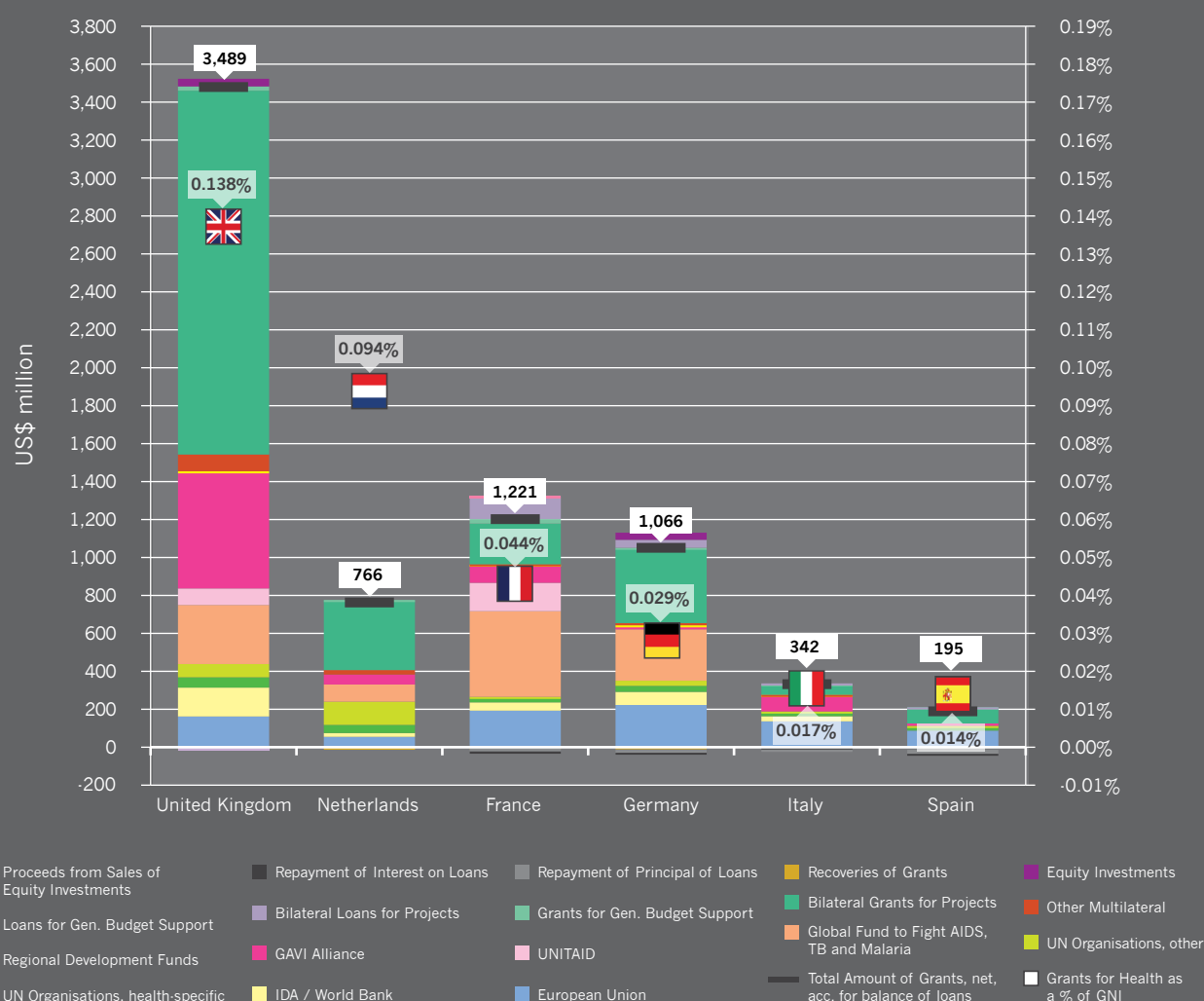
Despite this increasing share of loans in EU OECD-DAC total ODA, only three AfGH EU donors use lending mechanisms as part of their health programmes. These are France (9% of health ODA), Germany (4%) and Italy (1%).

Equity investments continued to grow as part of European non-grant health ODA in 2013. This is in line with trends in total ODA. Germany and the UK disbursed health ODA in the form of equity investments,

albeit relatively small shares of their total health disbursements (Germany 3% and UK 1%).

In 2013, AfGH EU donors continued to favour multilateral channels over bilateral grants, with the exception of the UK (56%) and the Netherlands (47%). Both of these applied a more balanced approach. Italy (16%) and France (19%) channelled the smallest percentages bilaterally, followed by Germany (37%) and Spain (39%).

**FIGURE 7: EUROPEAN MAJOR ECONOMIES:
MAIN COMPONENTS OF ODA FOR HEALTH AND ODA GRANTS IN RELATION TO GNI, 2013**



Key Recommendations

As the future of financing for development is being debated and decided upon, general ODA and ODA for health remain essential components – particularly for the world's poorest people. Achieving Universal Health Coverage (UHC) – where all people are able to access quality health services without discrimination whenever they need them and without financial hardship or fear of falling into poverty – requires investments, including through international aid.

AfGH calls on European donors, in particular the six EU countries that are the focus of this paper – France, Germany, Italy, Netherlands, Spain and the UK

– and the EU institutions, to protect and promote the allocation of sufficient public resources to health.

AfGH therefore puts forward the following recommendations:

- * European donors must continue to increase ODA and firmly advocate for a renewed international commitment to reach 0.7% of GNI within a concrete and verifiable timetable in the context of the 'Financing for Development' process. Following the recent re-commitment of the 28 EU donors to their collective and individual ODA targets in the post-2015 framework, EU leaders at the European Council on 25-26 June 2015 must now go a step further and agree on a concrete timetable for the achievement of the 0.7% target by 2030 at the latest.
- * All European donors should strive to reach 0.1% GNI for health ODA. They should significantly increase health transfers (with a continued focus on grants), in order to close the substantial resource gap of more than US\$22 billion.
- * Non-grant transfers such as ODA loans and equity investments play an increasing role in international development finance. European donors must ensure that this is not to the detriment of increases in ODA grants, especially in the health sector and in support of the world's poorest people.
- * European OECD-DAC members must advocate for a change in OECD-DAC reporting practices to allow more specific coding of projects to make OECD data more accurate and increase transparency and accountability. This should include methods to code expenditure according to more than one purpose, and multiple countries or regions.

1 http://www.consilium.europa.eu/en/meetings/fac/2015/05/st09241-en15_pdf/

2 2001 WHO Commission on Macroeconomics and Health found that if OECD-DAC donors contributed a minimum of 0.1% of GNI to global health it would bridge the gap between current health expenditure and the US\$44-60 per capita (now updated to US\$86) that is needed to deliver health for all in low-income countries. WHO Commission (2001): Investing in health for economic development. Available at: whqlibdoc.who.int/publications/2001/924154550x.pdf

3 In constant prices. Source: OECD Stat database

4 http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/ec/85349.pdf

5 <http://www.oecd.org/dac/stats/documentupload/ODA%202014%20Technical%20Note.pdf>

6 <http://www.oecd.org/dac/stats/documentupload/ODA%202014%20Technical%20Note.pdf>

7 AfGH's project-by-project review exercise and related research is currently limited to 17 of the 22 European OECD-DAC members and is excluding data on Czech Republic, Iceland, Poland, Slovakia and Slovenia.

8 AfGH report 2014, Health Financing: Unpacking trends in ODA for Health, January 2015

9 Recent (May 2015) EU position for Addis includes: "Innovative financial instruments, such as blending using equity, loans and guarantees, can be important for mobilising private investment for policy priorities that support sustainable development and poverty eradication... To harness the potential of the private sector and mobilise additional private finance, including from foundations and philanthropy, the right incentives need to be set, including through policy and regulations." See http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/ec/85349.pdf

10 OECD Stat database, data extracted on 6 May 2015

11 There are many different interpretations of the OECD-DAC guidance on how equity investments from a Development Finance Institution (DFI) or other similar bilateral agencies should be recorded as ODA. For more information, see the DFID public consultation on the arrangements for reporting this type of ODA: <https://www.gov.uk/government/consultations/department-for-international-development-statistical-consultation>

12 Institute for Health Metrics and Evaluation, Financing Global Health 2013: Transition in an Age of Austerity <http://www.healthdata.org/policy-report/financing-global-health-2013-transition-age-austerity>

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