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WHO PAYS FOR HEALTH?

TRENDS IN ODA FOR HEALTH

ADVOCACY REPORT
DECEMBER 2013

Who Pays for Health?
Advocacy Report
December 2013

Trends in ODA for Health...

Cover image:
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* All of the information in this report was correct as of December 2013.

Executive Summary

In this annual report on Official Development Assistance (ODA) for health, Action for Global Health (AfGH) examines the disbursements of selected European donors to global health, as compared with international targets and recommendations and the commitments they have made.

The report examines in-depth official Organisation for Economic Cooperation and Development (OECD) figures for ODA. Through a systematic project-by-project review, it gives an estimation of ODA to global health up to 2011 (latest data available). Finally, it critically reveals how much money was actually transferred to developing countries.

Most donors included in this report show a trend of decreasing ODA, particularly in recent years, following the economic crisis.

On ODA in general, our research shows a decline in the volume of ODA, pushing Development Assistance Committee (DAC) members even further away from the agreed target of 0.7% of Gross National Income (GNI) for development.

As a result of this trend, the actual gap between the volume of ODA grants provided by all 23 DAC Member States, and the volume if the 0.7% of GNI target is reached, is close to US$200 billion.

Only Denmark, Luxembourg, Norway and Sweden reached the 0.7% target in 2012.

When considering the 17 European DAC countries, only Denmark, Luxembourg, Norway and Sweden reached the 0.7% target in 2012. As a whole, all European DAC members combined showed a downward trend from 2009 which brought their ODA as a percentage of GNI to 0.35% in 2012.

There is a general trend among all European donors of decreasing health ODA as a percentage of GNI. Even those countries traditionally considered 'health champions', which reached the international recommendation of 0.1% of GNI for health (Denmark, the Netherlands, Norway and Sweden), seem now to be in retreat. The only exception is the UK, which is increasing its health ODA as a percentage of GNI.

As a result of governmental budget cuts, most EU donors have failed to meet their commitments on global health. The Netherlands and Spain have made the deepest cuts to ODA for health in 2009 and 2010, while Italy made big cuts in 2009.

Between 2010 and 2011, Spain cut health ODA by 45%, while Italy reduced its health ODA by 60% between 2008 and 2009. Together with Austria, Greece and Portugal, Italy remains one of the lowest contributors of health ODA among the European DAC countries.

The UK, however, has increased health ODA every year since 2008, reaching the international recommendation of 0.1% of GNI for health in 2011.

For most donors, cuts to global health follow a trend of cuts to overall ODA. The exception is Spain, which has cut health ODA more than other sectors.

There is a general trend among all European donors of decreasing health ODA. The exception is the UK which reached the international recommendation of 0.1% of GNI for health in 2010.

Action for Global Health's analysis of ODA contributions to global health also takes into account countries' economic capacity. Starting with an analysis of general ODA, it becomes clear that some countries with large economies, which make up the largest volume of ODA contributions, appear to be the most generous donors.

But when we look at economic capacity, these countries are often revealed to be surprisingly poor performers. Given their large economic capacity, Germany, Italy and Spain provide meagre support to the health sector, contributing between 0.019% and 0.031% of GNI (well below the 0.1% target).

A number of donors, notably the Netherlands and the EU institutions, include a wider range of international issues for international development ministries to address.

These include climate change, which diverts funding which might otherwise be available for countries to deliver on their commitments to global health. A number of donors are also increasing their use of loans as an aid modality, which must be repaid with interest.

Action for Global Health is a civil society network bringing together European NGOs in more than 70 countries. It provides insight into the lack of ODA for health. It calls EU donors to meet their commitments to global health to achieve international development goals.

In particular, it highlights a worrying trend that the wealthiest European nations give proportionally less than the poorest nations, both on general ODA as well as on health ODA.

Introduction

Debates on global health focus on how to conclude the 'unfinished business' of the Millennium Development Goals (MDGs), as well as addressing new health challenges and gaps in the next framework. EU policy-makers are accountable for the commitments they have made to global health.

Improving access to healthcare is a widely acknowledged means of improving public health and supporting people, families and communities to lift themselves out of poverty.

Health enables individuals to take up opportunities for education, employment and self-determination. The economic impacts of investments in health are well-documented.[1]

In the last two decades, global health has advanced as never before. The global efforts behind the MDGs, as well as the general prosperity and development of countries, have led to improved access to health promotion, prevention, treatment and care, and to overall better life expectancy.

But unacceptable differences remain both between developed and developing countries and within countries. One billion people do not have access to essential medicines nor do they receive the healthcare that they need.

The most pressing health issues of the 21st Century are the burden of poverty; communicable diseases such as HIV, TB and malaria; neglected tropical diseases, as well as emerging chronic and non-communicable diseases, such as cardiovascular disease, cancers and diabetes.

Ageing populations and urbanisation, particularly where they are not planned for, are challenges that put pressure on health systems. These are already under threat because of limited funding, limited access to commodities and products, and lack of financial coverage for health services.

Global leaders, experts and civil society working in global health acknowledge the need for a more holistic approach. In the coming years, donors should prioritise health systems, respond to specific health needs and address financial, cultural, political and trade barriers that prevent millions of people from accessing quality health services.

For many developing countries, the basic investment of US$60 per capita per year by 2015 – the estimated minimum required to deliver essential health services – remains a bold aspiration.[2] ODA is one of the tools we have to promote the economic development and welfare of developing countries and enable them to improve health outcomes.

However in recent years, a worrying trend has emerged of decreasing ODA, and especially health ODA, in many donor countries. This is true even for those considered to be strong performers, well above the 0.1% of GNI recommended by the WHO Commission on Macroeconomics and Health.[3]

El Salvador: The burden of communicable diseases, such as HIV, is one of the most pressing issues worldwide. A patient holds their antiretroviral drugs essential for the treatment of HIV.

Action for Global Health's 2013 report aims to inform and support advocates, technical specialists, decision-makers and citizens to evaluate the EU's contribution to global health.

EU policy-makers are accountable for the commitments they have made to global health. This report articulates how well they have performed in delivering on those commitments. Through its latest study, AfGH is advocating for a more proactive role for EU OECD-DAC donors in enabling poorer countries to ensure better health outcomes for their populations.

The report shares new evidence and analyses about the volume and quality of ODA for health in the EU, in six EU countries – France, Germany, Italy, the Netherlands, Spain and the UK – as well as the EU institutions. The first section looks at cross-European trends. We analyse trends using the latest data available on the OECD database:[4] health ODA from 2007 to 2011, and over-arching figures for ODA up to 2012.

In addition to AfGH focus countries and the EU institutions, the cross-European analysis includes a comparison with other European countries. Thus, the analysis demonstrates how the biggest EU economies measure up against some of Europe's strongest champions for international development.

The second section provides detailed country analysis of the six focus countries and the EU institutions.

Unpacking ODA: A Methodological Note

This report shares the findings of a research methodology that aims to produce a precise assessment of ODA contributions for human development and health. The methodology was originally developed by the Medical Mission Institute Würzburg (MMI). Since 2010, AfGH and MMI have collaborated on this methodological approach for the comprehensive analysis of the donor performance of the 17 European members of the OECD-DAC.

Our present research covers the periods 2007-2012 for total ODA and 2007-2011 for health ODA, according to the availability of official OECD data. Our analyses focus on ODA disbursements, since disbursements represent actual expenditures and thus, shall be used when measuring donor performance against targets, commitments or promises.

The statistical systems of the OECD-DAC were the primary data sources for the analyses as these constitute the most reliable and comprehensive source of information on ODA flows.

Total ODA as 'accepted' by the OECD (referred to as 'official OECD figures') includes expenditure items and accounting entries that do not represent actual transfers of financial, technical or personnel resources from donor to developing countries.

These include debt relief, imputed costs for students from developing countries, costs for refugees in donor countries, and administrative costs. Although expenditure for refugees and imputed student costs in donor countries are extremely important, these items do not contribute to the need for external financial assistance to overcome poverty and improve health conditions in recipient countries.

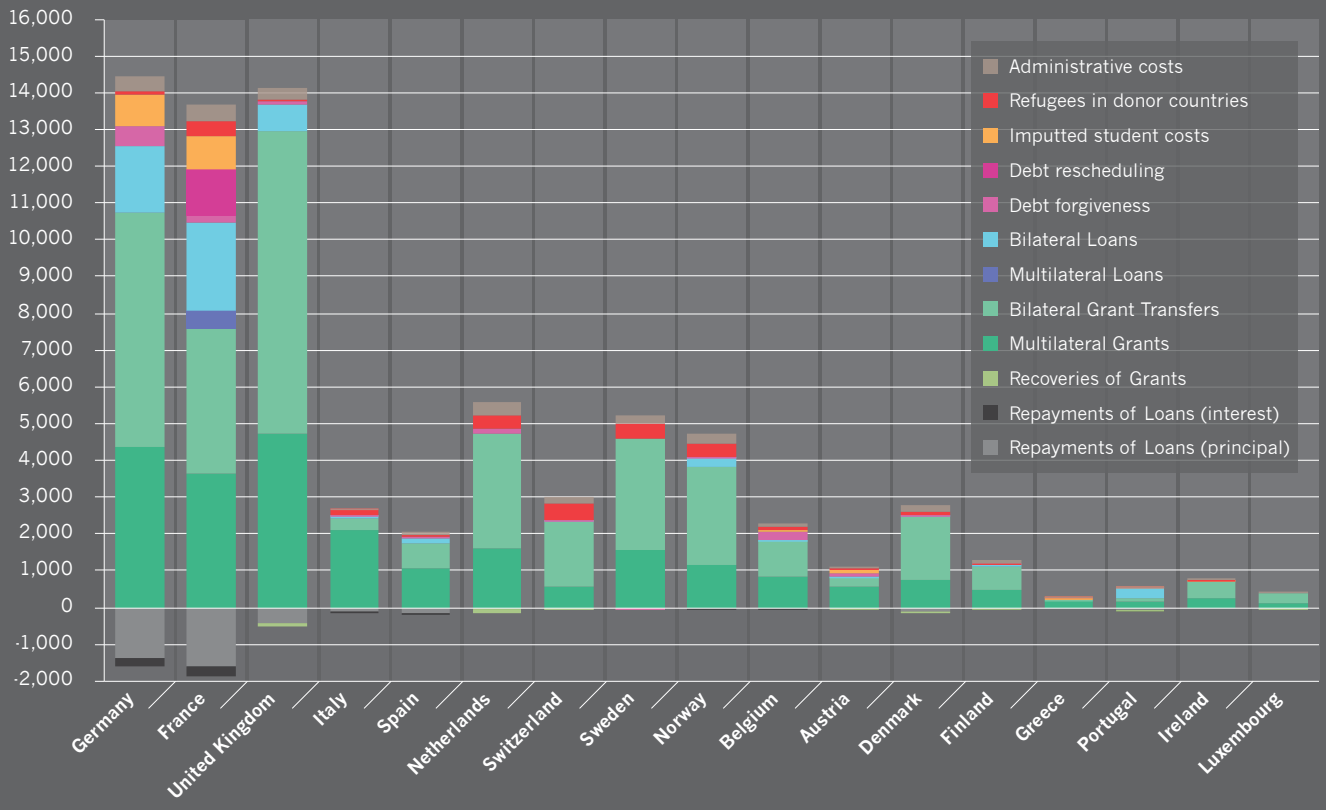
Moreover, some DAC countries provide a considerable part of their ODA in the form of loans. This does not take into account the true needs of those countries and populations worst affected by poverty, hunger, and disease. The poorest nations are not in a position to accept and repay ODA loans. But even for Middle-Income Countries (MICs), there is an increased risk of excessive indebtedness in the future.

In order to facilitate a more in-depth understanding, we have disaggregated ODA disbursements into the following:

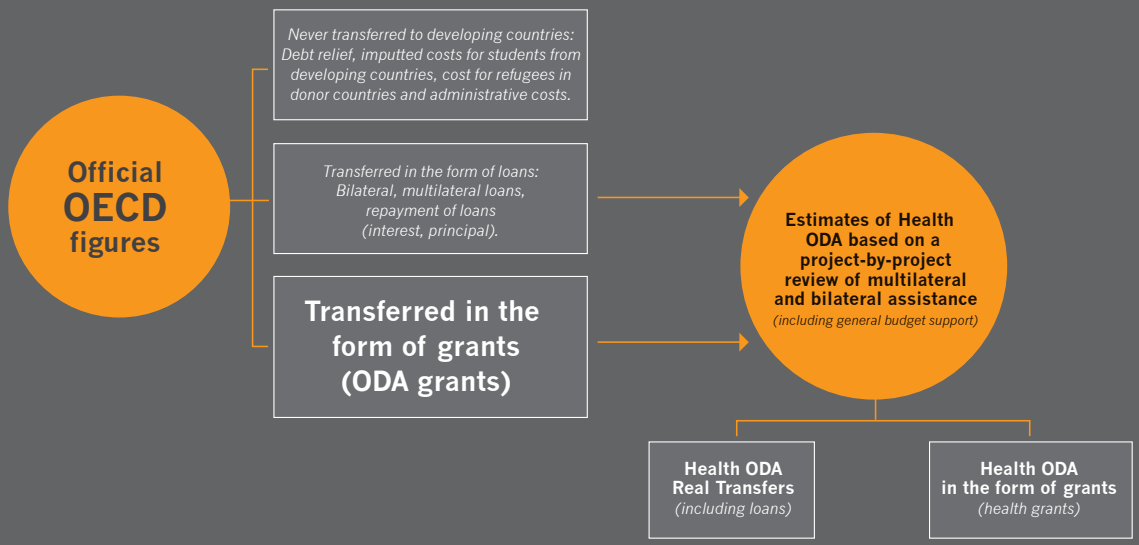
* Official OECD figures;
* Real resource transfers (after deducting debt relief, imputed costs for students from developing countries, costs for refugees in donor countries, and administrative costs); and
* Grant transfers (after deducting loans).

Fig. 1

European DAC Members: Components of OECD-accepted ODA showing in addition repayments of interest on loans in 2012, US$ million (current).



Methodology Visualisation



PROJECT-BY-PROJECT REVIEW

A second aspect of the methodology is a focus on the accuracy of reporting of ODA for health in the OECD database. For this, we conducted a systematic, project-by-project review of all aid activities financed by donor countries or relevant multilateral organisations and categorised under health and population policies/ programmes and reproductive health sectors.

Using a key word search, we scrutinised all projects in other sectors to see which were relevant to health. We examined the project descriptions in the OECD database, and sought clarification from implementing agencies through web-based sources or direct communication. This allowed us to create a complete and consolidated database of all programmes, projects and components that identify health as their main objective.

We sought to include donors' multilateral contributions as part of their ODA to health. For this, we calculated the proportion of each relevant multilateral's activities that support health. Then we established the corresponding proportion accounted for by each donor's contribution to the respective organisation.

We also took into account health financing through General Budget Support (GBS). These amounts are calculated individually for each recipient country on the basis of the annual disbursements for GBS going to this country and the percentage share of health expenditure in relation to total government spending in the respective year.

As a number of donors provide part of their bilateral health assistance in the form of loans or equity investments, we attempted to calculate the imputable repayments resulting from lending in this area. In the absence of sector-specific data, we use the health share of all ODA commitments made on a repayable basis during the previous years for which this information is available (1995-2010). Multiplying this percentage with the total amounts received by the donor country from ODA recipients in the respective year, we obtain the approximate volume of repayments accruing from lending for health investments.

By deducting this figure from gross disbursements, we can determine the net ODA contribution for health and the ratio in relation to GNI, which represents the main indicator for evaluating the financial effort in support of health promotion.

We show loans and equity investments separately, because these financing modalities are not suitable for supporting the countries and populations most in need. Moreover, loans only represent a weak financial effort as developing countries ultimately need to repay the capital plus interest. Furthermore, a significant proportion of these funds come from capital markets. We focus our analysis on transfers made in the form of grants. These represent the amount of resources that can be spent to support the more disadvantaged countries and essential areas of human development, such as health.

For more detailed information on our methodology, please go to or website at: www.actionforglobalhealth.eu.

Cross-European Analysis of Official Development Assistance (ODA), 2007-2012

WHO PAYS FOR HEALTH? **ADVOCACY REPORT**

Trends in ODA and in ODA for Health

The contributions of Member States of the DAC to ODA increasingly reflect the de-prioritisation of human development. This policy shift has become widespread in recent years. With the economic crisis given as a justification, governments have cut budgets and reallocated funding to stimulate domestic economies.

The result is the volume of ODA provided by 23 DAC countries to developing countries, according to official OECD accepted figures and our calculations,[5] declined in 2011 for the first year since 2006. This negative trend appears to have continued in 2012 (according to our analysis of preliminary data).[6]

The consequence of this decline in ODA volume is pushing DAC members even further away from the 0.7% of GNI target (indicated in Fig. 2 opposite).[7]

As a result, there is a gap of nearly US$200 billion between the volume of ODA grants provided by all 23 DAC Member States and the volume that would be achieved if the 0.7% target were reached.

This is demonstrated in Fig. 2 opposite which shows the aggregate performance of European DAC countries according to OECD accepted, real and grant transfers, and the financial gap towards the 0.7% target.[7]

Further to this, there is a worrying trend in grant reduction and/or stagnation, and an increase in the amount of loans donors include in official ODA reporting. According to the OECD database,[8] there has been an increase among all donors in loans disbursements from US$13.8 billion (at constant prices) in 2005 to US$23 billion in 2011.*

This includes all DAC countries and the EU institutions. The volume of loans from EU DAC countries have more than doubled in this period from US$3.3 billion in 2005 to US$8.2 billion in 2011, mainly because of France and Germany. In 2011, their loan disbursement as part of ODA was US$4 billion and US$2.7 billion respectively.

In respect of the EU institutions, in 2011 these accounted for more than US$5.4 billion of ODA in the form of loans, almost ten times more than the volume accounted for in 2005.

There are many discussions around loans being counted as a form of ODA. ‘Many contest it. This is because countries either need to repay the capital, plus interest, or large volumes of loans are counted as ODA, even though they do not fully meet the OECD’s definition of aid, or are raised on capital markets.[10]

*Data from 2012 not yet available.

Fig. 2

Volumes of ODA provided by 23 DAC member states in constant US$, billion.
(Adjusted for exchange rate and inflation, base year 2011, grants accounting for balance of loans)

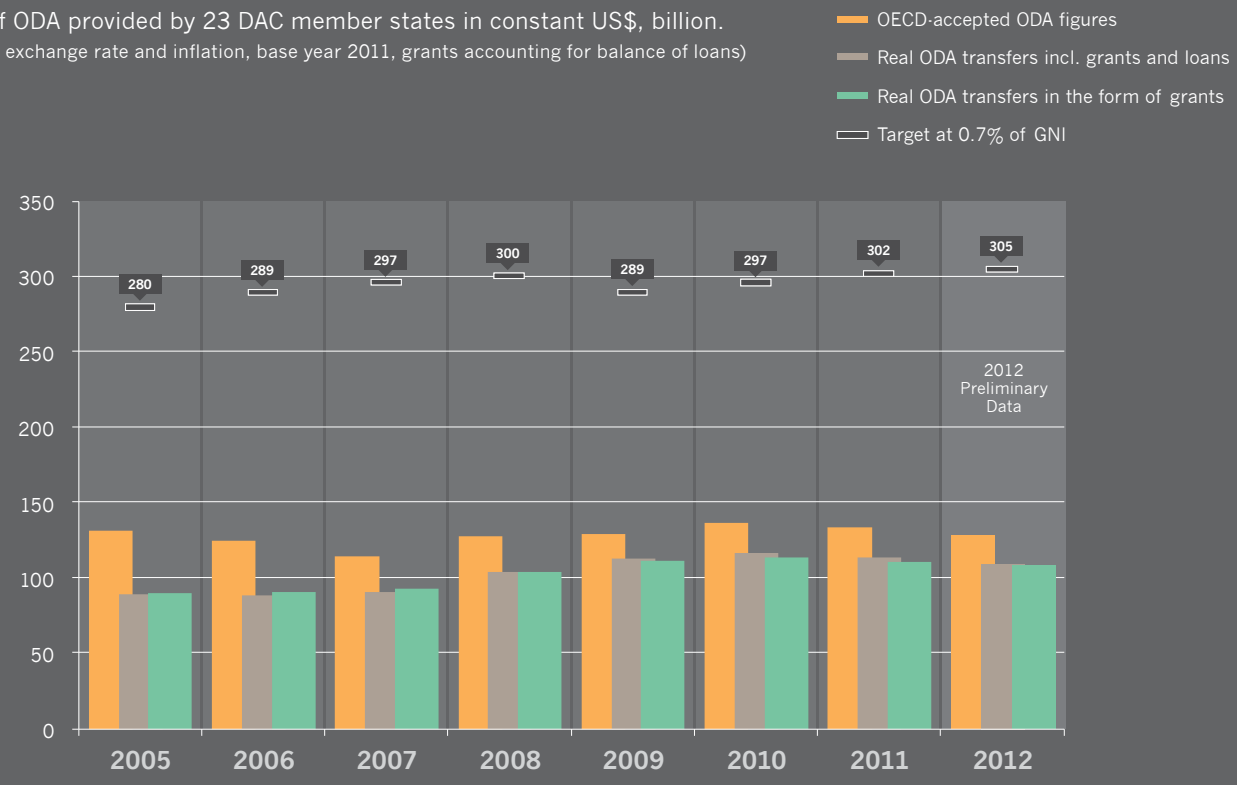
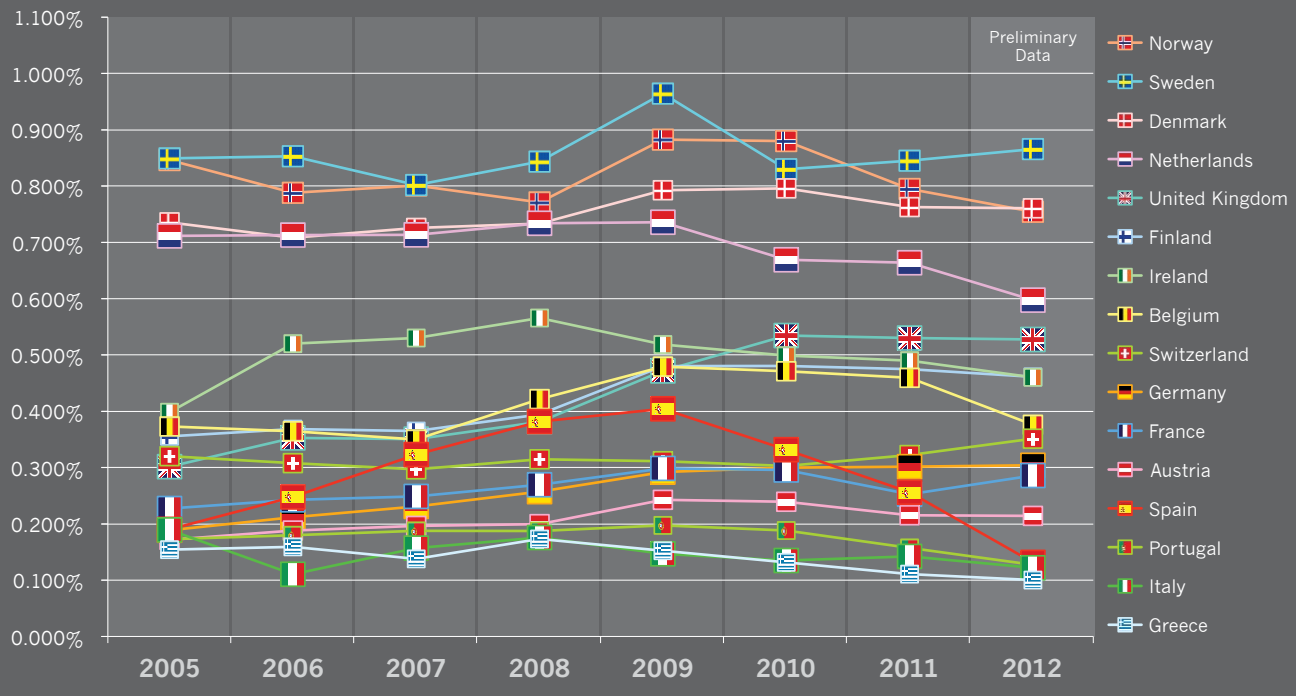


Fig. 3

European DAC Members: Total Real Transfers of ODA Grants in relation to GNI.
(Accounting for the balance of ODA Loans, preliminary figures for 2012)



Donors are increasing the amount of loans they include in their reporting of official ODA.

WHY MEASURE ODA CONTRIBUTION BY ECONOMIC CAPACITY?

Donor countries have different economies and operating budgets. Thus, it is not fair to compare absolute volumes of ODA contributions without also considering the resources available. Setting targets and monitoring contributions to ODA as a proportion of GNI is a more equal way to compare and monitor contributions. This is the purpose of the 0.7% of GNI target for ODA in total, and the 0.1% of GNI target for ODA for global health in particular.

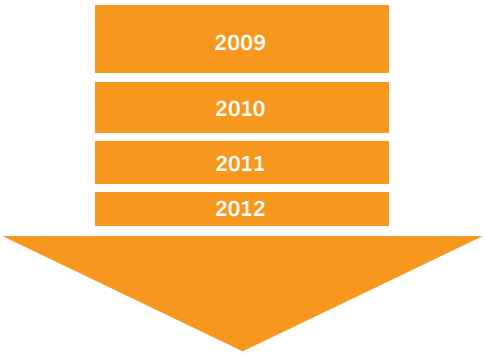
In this way, we can examine and compare each donor's contribution in relation to their capacity to contribute.

Therefore, the 23 DAC countries, as a whole, have failed to make progress towards the 0.7% of GNI target, while contributions according to economic capacity are actually declining.

When looking at data from all the DAC countries combined, ODA grants in relation to GNI only reached 0.26% in 2011, down from 0.27% in 2009. Preliminary data for 2012 show a further decline to 0.25%.

When considering all 17 European DAC member countries,[11] only Denmark, Luxembourg, Norway and Sweden reached the 0.7% target in 2012.

As a whole, all European DAC members combined began a downward trend of their ODA as a percentage of GNI in 2009, which brought it to 0.35% in 2012.



All European DAC members combined began a downward trend of their ODA as a percentage of GNI in 2009, which brought it to 0.35% in 2012.

0.35%

Real ODA grant transfers to developing countries have decreased since 2011.

IN CONCLUSION

It is clear that some countries with large economies may make up the largest volume of ODA contributions, and therefore appear to be the most generous donors. But when we look at economic capacity, these countries are often revealed to be surprisingly poor performers. Their financial effort is actually very poor when you consider their economic capacity to give.

Official Development Assistance, overall findings

- Real ODA grant transfers to developing countries increased in the years 2006 to 2010. This positive trend for ODA reversed in 2011, and preliminary data for 2012 suggests the current decline will continue.
- The gap between real ODA grant transfers and the combined 0.7% of GNI of all DAC countries amounts to nearly US$200 billion. This gap refers to the difference between 0.7% of DAC countries' GNI (US$305 billion in 2012) and real ODA grant transfers (US$108.5 billion in 2012).
- Most DAC members are contributing increasingly smaller proportions of GNI to ODA, while some have cut their contributions substantially. Thus, contributions measured by economic capacity are declining. Progress towards the 0.7% of GNI target is falling away.
- Donors are increasing the amount of loans they include in their reporting of official ODA. Loans are a weaker and controversial form of aid for social development, as developing countries ultimately need to repay the capital plus interest.

Total real transfers of ODA grants, key findings for focus countries

- France's total real transfers of ODA grants contribution, as a proportion of GNI, increased from 0.23% in 2006 to 0.3% in 2010. It then decreased to 0.25% in 2011 and, according to preliminary figures, it has slightly increased in 2012.[12]
- Germany's contribution increased from 0.19% in 2006 to 0.30% in 2010. It remained the same until 2012. The small increase of ODA grant disbursements reported for 2012 is highly insecure because the respective data on ODA grants had to be adjusted downward by the OECD for the year 2011.
- Italy contributed 0.19% of GNI to ODA in 2005 but, after some fluctuations, it cut its support for international development to only 0.12% of GNI in 2012 (according to preliminary figures).
- The Netherlands met the 0.7% target, through real ODA transfers in grants, from 2005 until 2009. However, since then, there has been a significant decrease, reaching 0.66% in 2011. The cut will likely be even more severe in 2012.
- Spain made the deepest cuts to international development. Having increased support to ODA considerably between 2005 and 2009, and reaching a historical high of 0.40% of GNI, Spain cut ODA grant transfers to 0.26% in just two years. Preliminary data for 2012 indicate that Spain has again made deep cuts, with its contribution to ODA approaching 0.13% (about the same level as Italy).
- The UK significantly increased its contribution to ODA from 0.33% of GNI in 2007 to 0.53% in 2010, and this has not increased since, although there is a commitment to achieve the 0.7% target in the 2013-2014 budget.

European Donor Performance for Global Health

There is a general trend from all European donors to decrease health ODA as a percentage of GNI. Even those countries traditionally considered 'health champions', which reached the 0.1% target, seem now to be in retreat. The only exception is the UK which is increasing it.

The 2001 WHO Commission on Macroeconomics and Health concluded that if DAC donors contributed a minimum of 0.1% of GNI to global health, it would be possible to deliver health for all in almost all Low-Income Countries (LICs). This was the level of investment required to bridge the gap between current health expenditure and the US$60 per capita by 2015 that is needed. To date, few donors have reached this target.

Most importantly, as Fig. 4 and 6 show, there is a general trend from all European donors to decrease health ODA as a percentage of GNI. Even those countries traditionally considered 'health champions', which reached the 0.1% target (Denmark, the Netherlands, Norway and Sweden), seem now to be in retreat. The only exception is the UK which is increasing its health ODA as a percentage of GNI.

Among the selected focus countries, the UK stands apart as the only donor to achieve the recommended 0.1% of GNI contribution to global health in 2011.

The Netherlands and Spain have made the deepest cuts to ODA for health since 2010, while Italy reduced its ODA for health from 2009. Spain cut its ODA for health only between 2010 and 2011 by 45%, while Italy reduced its health ODA by 60% in 2009. Among the European DAC countries, Italy remains one of the lowest contributors of ODA for health, together with Austria, Greece and Portugal.

Given their economic capacity, Germany, Italy and Spain provide meagre support to the health sector, contributing between 0.019% and 0.031% of GNI. As Fig. 5 shows, France, Germany, Italy and Spain together account for a gap of over US$7 billion between the actual volume of health ODA and the volume reached if they achieve the 0.1% of GNI target.

This would be equal to the resources required for treatment, care and support for 13 million people living with HIV, which is the target treatment for 2015 according to the UNAIDS investment framework.[13 14]

Recognised as a determinant of many other aspects of development, health underpins the UK's overall development strategy and accounts for 18.7% of its portfolio. When looking at all aid flows including grants and loans, all other selected focus countries devoted less than 15% to health ODA in 2011, with Germany and Spain at unacceptable levels well below 10% (9.4% and 8.5% respectively). The EU institutions stand out as the donor with the greatest potential to improve their support of the health sector, since only 8.1% of their ODA is allocated to health.

Fig. 4

European DAC Members: Trend of ODA Grants for Health in relation to GNI, 2007 to 2011, in mio. constant US$.

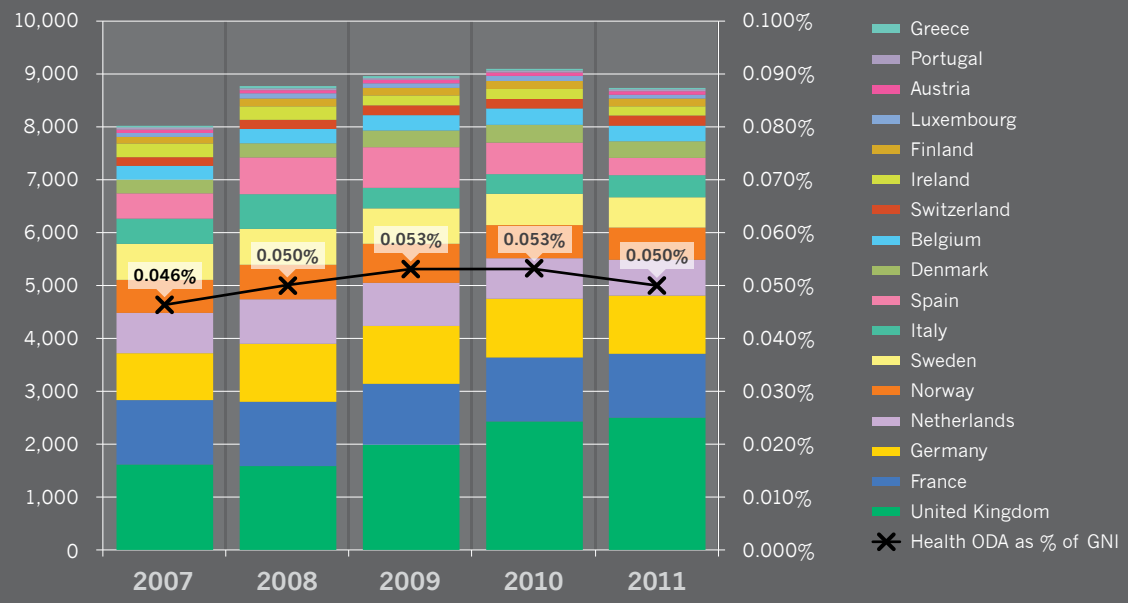
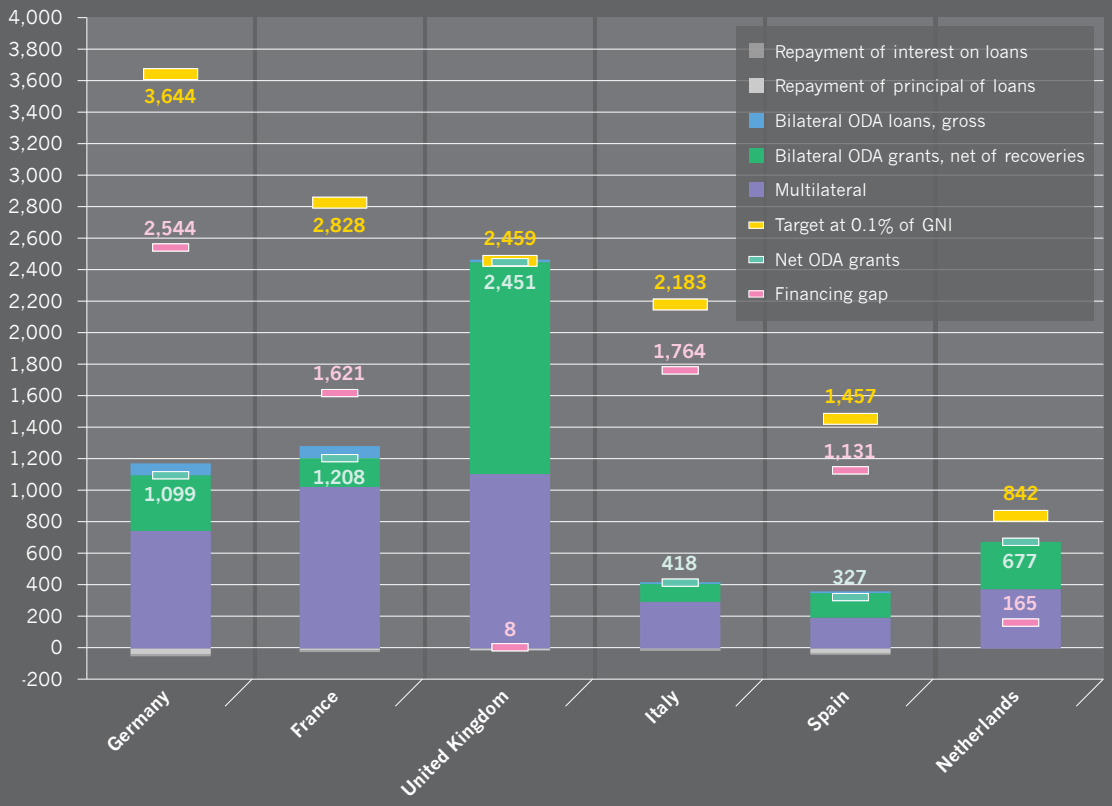


Fig. 5

Components of ODA for Health and financing target at 0.1% of GNI in 2011, US$ million, current.

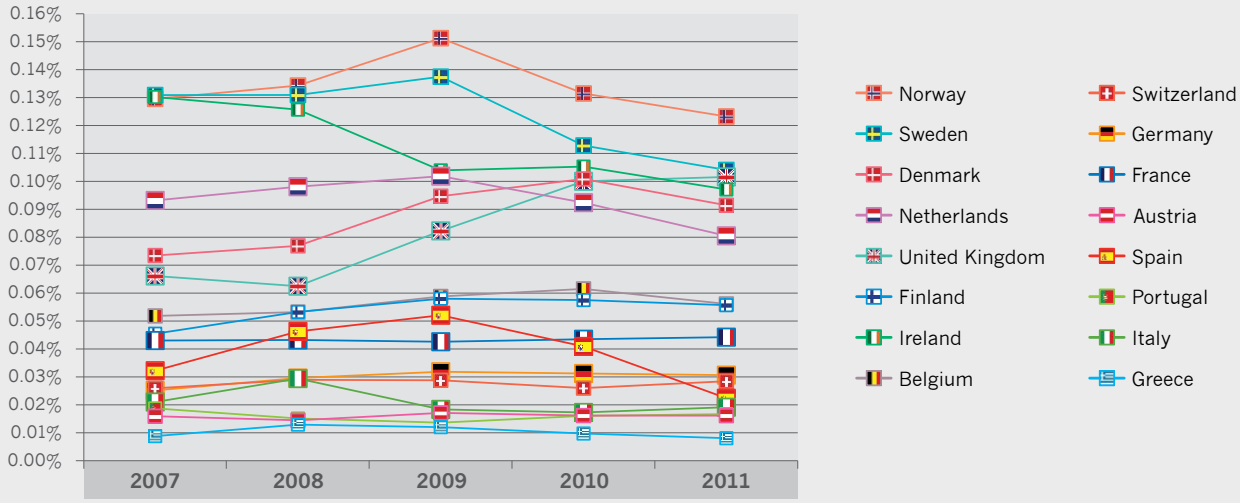


In general, most European countries are either decreasing their health ODA contributions as a percentage of GNI, or their contributions are stagnating at low levels.

ODA to global health, key findings for AfGH countries

- In general, most European countries are either decreasing their health ODA contributions as a percentage of GNI, or their contributions are stagnating at low levels. This is with the exception of the UK which has steadily increased its health ODA since 2008 and reached the 0.1% target in 2010.
- The Netherlands (although it still ranks second among the focus donor countries), and Spain, have made the deepest cuts to ODA for health since 2009-2010.
- The Netherlands decreased ODA for global health from 0.102% of GNI in 2009 to 0.081% in 2011. Although it is still above average, the Dutch trend is discouraging.
- The Spanish contribution to health ODA has continued to decrease, down from 0.052% of GNI in 2009 to 0.022% in 2011. This trend is set to continue.
- The German contribution to ODA for health in the form of grants is, compared with capacity, very low and, at only 0.031% of GNI in 2011, far off the WHO's recommended target.
- The French contribution as a proportion of GNI remained relatively stable at 0.044% in 2011, although it is not even halfway to the WHO's recommended target.
- The Italian contribution to global health declined dramatically in 2009 and then stagnated at 0.017-0.019% of GNI.
- France, Germany, Italy and Spain remain significantly below the target of 0.1% of GNI for global health.

Fig. 6



European DAC Members: Trend of ODA Grants for Health in relation to GNI, 2007 to 2011.

Who Pays for Health? The Burden on Service Users

WHO PAYS FOR HEALTH? **ADVOCACY REPORT**

Who Pays for Health? The Burden on Service Users

In most developing countries, the health system is financed by national governments, donor funding and service users (patients) themselves. Although states should be the main contributors, the reality is very different. In many developing countries, around 30% of health expenditure is covered by out-of-pocket contributions from families.

HEALTH FINANCING IN KENYA

In Kenya, the Government contributes 34.1% of the health budget, donors approximately 30%, while households, or service users, are the largest contributors of health funds, accounting for 35.9%.

Under Kenya's current healthcare financing system, the largest percentage of healthcare costs is paid by service users at the point and time at which they access healthcare. Existing financing mechanisms assume that the majority of people can afford to pay for healthcare. However, existing waivers and exemptions are weak and do not protect the poor and vulnerable, which constitute close to 42% of the population living below the poverty line.

While paying for health services may not be a problem for the better off, it places a heavy financial burden on many households.

In a household survey carried out in 2007, 19% of respondents said monetary support to cover health costs came from friends and family members, while 7% of households had to borrow money. Another 7% of all households accessing health services had to sell their assets (land, domestic animals, etc.) to cover their health costs, as compared with 17% of the poorest households. In comparison, this had to be done in less than 1% of admissions amongst the richest households.

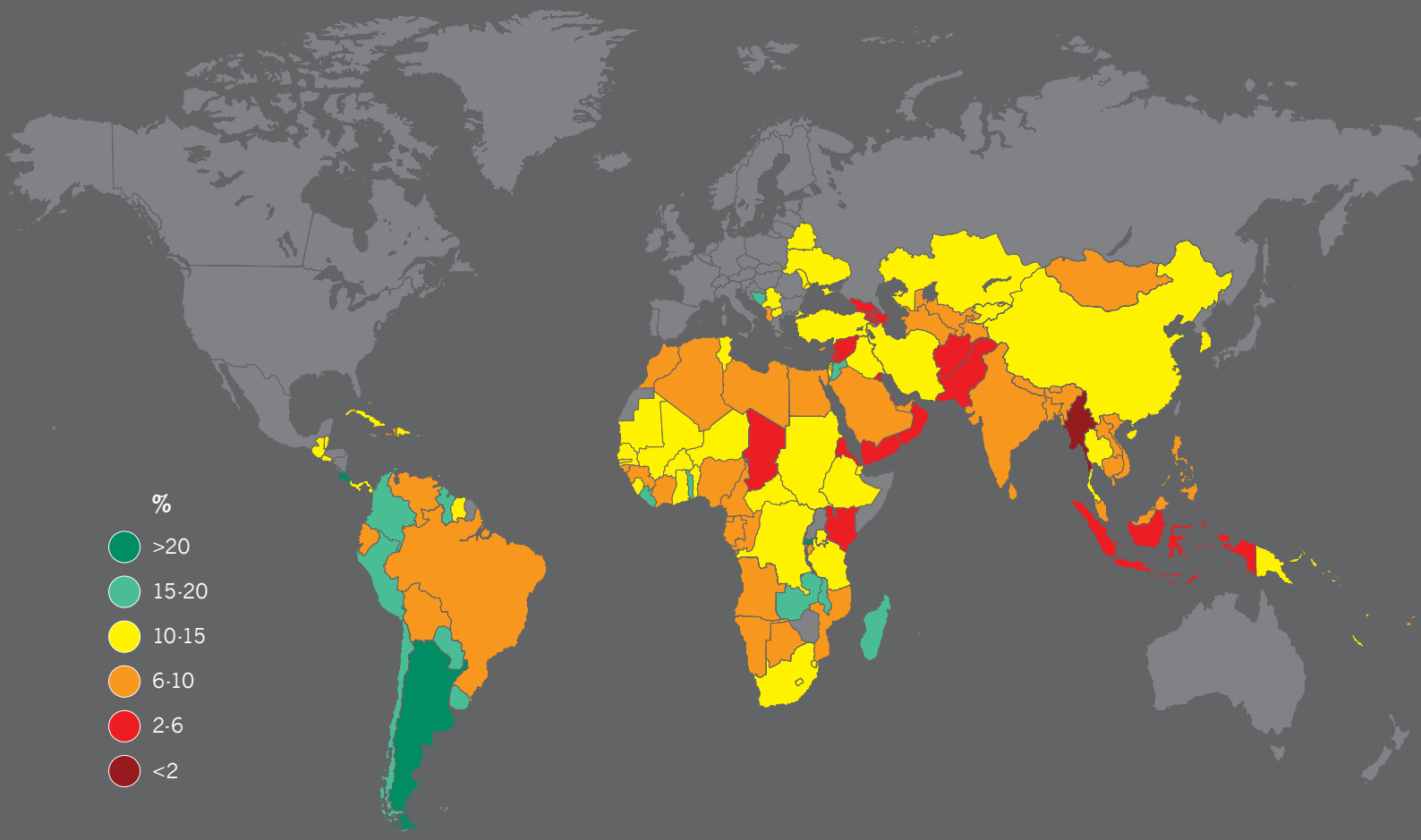
Beyond the figures and statistics, the way the poor and the rich respond to illness is also quite different. When the rich get sick, they go to a health facility and see a doctor. Their financial livelihood is not threatened, since their private health insurance will cover it. But things are different for the poor.

When a member of a poor household gets sick, first they will wait to see if they recover without medical assistance. When this does not happen, they may visit the local kiosk to buy medicines. Usually kiosks stock an assortment of painkillers and useless, often outdated, anti-malarials. Next is 'mitishamba' (traditional herbals), either self-prescribed or obtained from the local herbalist.

If all these efforts fail, only then will the household access formal medical treatment. In order to benefit from the formal public health system, poor households have to make a considerable sacrifice. This may involve the liquidation of household assets for the cash that is needed for transportation to health facilities, and to pay for consultation.

Case study based on findings by the Kenya Aids NGO Consortium (KANCO): Health financing in Kenya. [15]

General government expenditure on health as % of total government expenditure (2011).



Policies to Increase Access for the Poor: A Political Decision

Governments should make every effort to increase their health expenditure. Health financing policy instruments are critical to achieving equitable pathways towards Universal Health Coverage (UHC).

As set out in the 2010 World Health Report, governments need increased equitable funding for health through mandatory, progressive pre-payment mechanisms that include revenues from taxation and the elimination of out-of-pocket spending. Large-scale and compulsory pooling of risks and resources is needed to redistribute resources from the healthy and wealthy to the poor and sick.[16]

In Kenya, as in many other developing countries, the Government is allocating too few resources to health, barely reaching 5.9% of government expenditure between 2010 and 2011.

In 2001, African Health Ministers met at a special summit in Abuja and committed, in the 'Abuja Declaration', to allocate 15% of their national budgets to health. However, only six countries of the African Union (Liberia, Madagascar, Malawi, Rwanda, Togo and Zambia) have achieved the Abuja target.

A number of other countries (e.g. Djibouti, Ethiopia, Lesotho and Swaziland) are nearly there. The vast majority of African nations have not met their commitments.

But, as Fig. 7 opposite shows, even those countries that spend beyond the Abuja target, such as Malawi, Rwanda and Zambia, do not mobilise sufficient funds to cover the basic health needs of their populations.

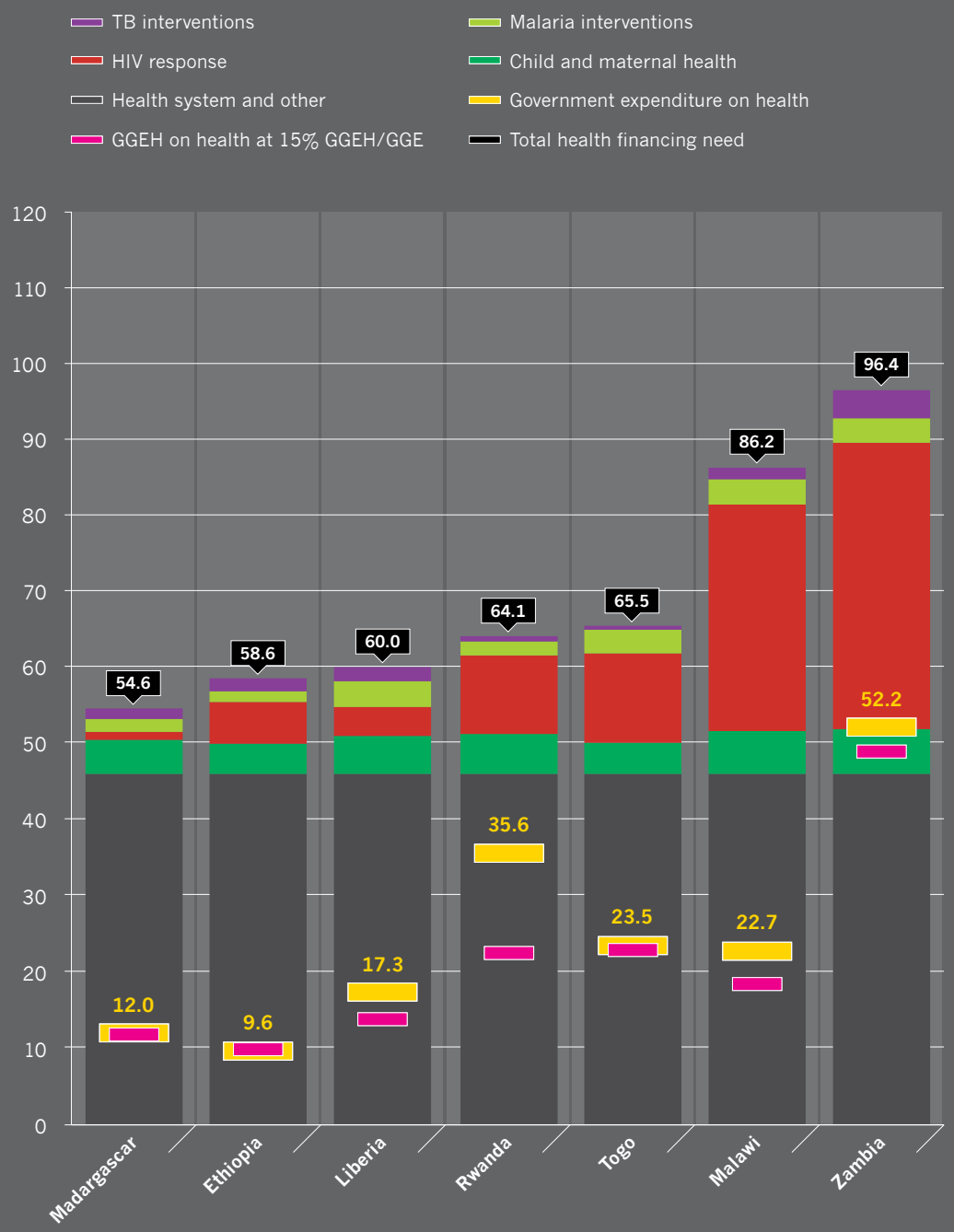
Governments of such poor countries could possibly adopt effective taxation and budget allocation measures that would increase public revenue. But even so, without foreign aid, access to healthcare will continue to depend on the patient's wealth and their geographic proximity to health facilities, along with other cultural and social barriers such as gender.

The EU and its Member States have committed to accelerate the achievement of the MDGs before the 2015 deadline. Despite the fact that some targets might not be reached by then, the current negotiations around the post-2015 framework offer the EU an ideal opportunity to promote some of the most off-track goals, including health.

In order to reach sustainable and inclusive development, EU donors have a role to play in making access to health equitable and ensuring funding is adequate to fulfil their commitments.

Fig. 7

Low income countries reaching Abuja Target: Minimum resource needs for health according to epidemiological criteria and government expenditure for health per capita, 2011, in 2010 US$.



The analysis is based on WHO assessment on LICs, global plans for HIV response, and fight against TB and Malaria, as well as epidemiological criteria for distribution of resources per country.

Fig. 8

Health Share of Total ODA Transfers (Grants and Loans) 2007 to 2011.

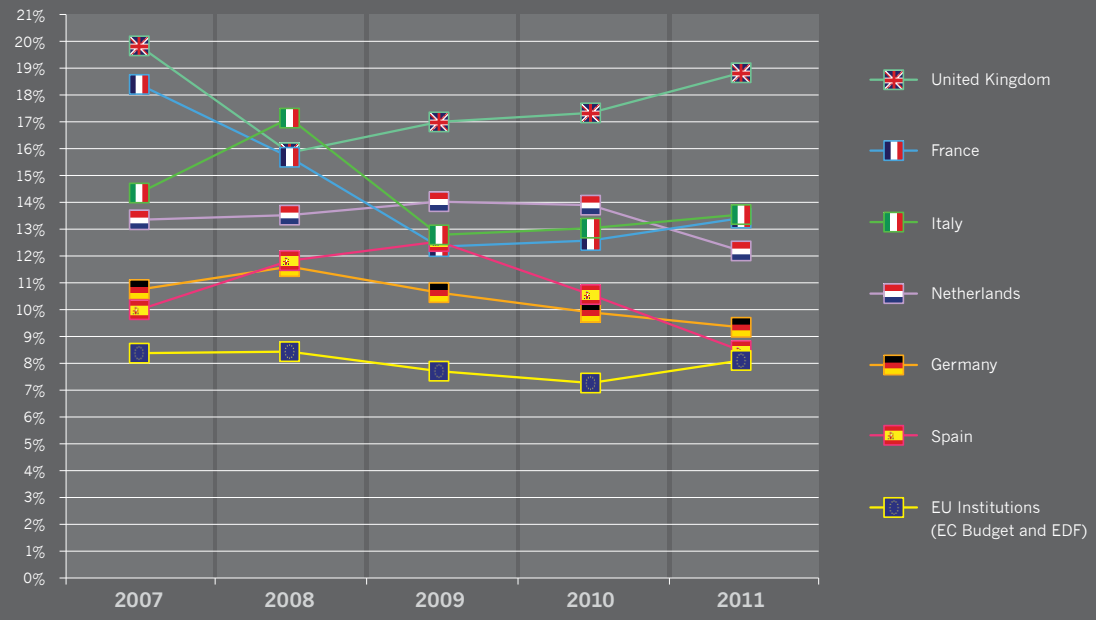
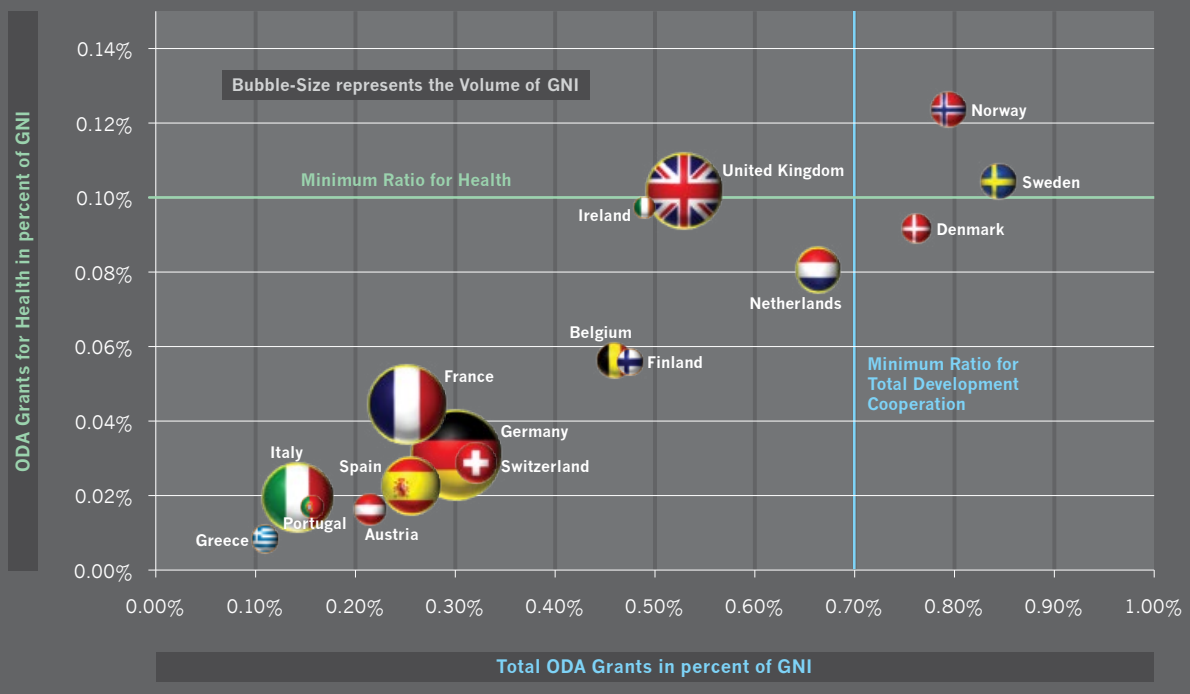


Fig. 9

ODA grants provided by European DAC countries in relation
to economic capacity, measured by Gross National Income in 2011.
(The calculation of grants takes account of the balance of ODA Loans including the repayment of interest)



Additional Resources for Health

WHO PAYS FOR HEALTH? **ADVOCACY REPORT**

Additional Resources for Health

Despite the economic crisis that has faced many donor countries, other financing mechanisms are in place or in preparation that could help donor countries reach their targets for development cooperation and international health.

A PROMISING TOOL: THE FINANCIAL TRANSACTION TAX

In January 2013, 11 EU Member States (Austria, Belgium, Estonia, France, Germany, Greece, Italy, Portugal, Slovakia, Slovenia and Spain) agreed to introduce a Financial Transaction Tax (FTT) in their countries within the enhanced cooperation procedure.

On the basis of the current directive, revenues of 35 billion euros could be generated annually. The allocation of FTT revenue for development financing is a great opportunity to safeguard increasing ODA and ODA for health in the coming years.

France has already introduced a small-scale FTT. It has allocated some revenues to health. But while this could have been a case of increased resources for health, it is in reality an example of 'fungible funding'. France re-allocated ODA that had previously been allocated for health to other sectors. Thus, total resources for global health did not increase.

Civil society organisations are therefore advocating that an FTT isn't just used to replace existing commitments but to bridge the gap between ODA for health and global health financing needs.

The FTT offers the possibility of long-term and sustainable development financing. The processes around the introduction of an FTT at EU level are an extraordinary opportunity to secure the future of development financing.

However, the use of innovative financing must be additional to current ODA and not an excuse for reducing the budgetary effort for global health and development.

José Manuel Barroso

President of the European Commission

"It's a question of fairness... It is time for the financial sector to make a contribution back to society."

OTHER INNOVATIVE FINANCING MECHANISMS

Air Tax Levy

France has instigated an air tax levy to fund global health. Similar to an FTT, an air tax levy results in a small amount from each ticket purchased being allocated to global health. It is a direct contribution from a consumable luxury to benefit health systems in developing countries. Today, nine countries have put this tax in place including six African countries.

€185 million

raised by France alone in 2012

International Financing Facility for Immunisation (IFFIm)

The IFFIm was set up in 2006 to ensure long and predictable commitments for immunisation. It uses long-term binding donor commitments to see 'AAA-rated' vaccine bonds issued that ensure large volumes of immediate funds. Since its creation, thanks to the leadership of the UK, this innovative tool has helped to raise US$3.4 billion.

Private Sector Contributions

Another funding source being considered to scale up international development financing is private sector contributions. The Netherlands, as well as others calling for 'value-for-aid', are making efforts to include private sector contributions as part of development aid. As private sector contributions in the health sector are mainly infrastructure investments, and quite limited in volume, AfGH has not included this in its current research.

The next section looks in greater detail at trends in ODA for health for the selected EU DAC donors and the EU institutions

US$ 3.4 billion

contributed by IFFIm from 2006 to 2012

Recommendations

Policy-Makers and Development Cooperation Agencies:

1. Member States of the European Union to reaffirm their commitments to 0.7% of GNI for ODA. The deadline for these commitments should be scheduled according to a pragmatic timetable, with year-by-year targets.
2. As part of national ODA commitments, 0.1% of GNI should be earmarked for financing the funding gap for the provision of global healthcare, as recently reviewed by WHO.
3. Government foreign policy conceptualises ODA as a fundamental part of foreign relations and long-term trade and partnership strategies and ODA financing should be ring-fenced so that funding for health remains predictable.
4. For governments to commit to raising additional revenue to contribute to ODA targets through innovative financing mechanisms, such as the Financial Transaction Tax (FTT).*
5. The next global framework for international development should include a shared but differentiated responsibility for financing healthcare between donor and recipient countries, as set out in the Universal Health Coverage (UHC) approach.

*The Financial Transaction Tax (FTT), often called a 'Robin Hood tax' or 'Tobin tax', is a tiny tax (between 0.005% and 0.5%) on selected products traded by the financial sector, such as equities, bonds, foreign exchange and their derivatives.

OECD and Development Cooperation Agencies:

1. Undertake a review of what modalities of ODA (grants, lending, in-country expenditures) contribute most to international development goals.
2. With regard to ODA reporting, allow more specific coding of projects, including methods to code expenditure according to more than one purpose, to make OECD data more accurate. Allow more transparency and develop a standard to publish all documents on project planning and implementation, following the examples of the International Development Agency – IDA and the Global Fund. These documents would best be linked to the ID reported to the CRS database.
3. With regard to quality assurance, monitor the quality of donor reports and provide appropriate support to ensure full and accurate information.

Civil Society:

1. For civil society to take part in country-specific ODA analysis which builds a transparent picture of what constitutes ODA and enables a rigorous approach to ensure that governments fulfil their individual commitments.
2. Strong civil society partners, including international NGOs, should work in partnership with governments to produce evidence about the impact and value of ODA for health, while at the same time holding governments to account.

European Donors in Profile: Where do they Stand on Global Health?

WHO PAYS FOR HEALTH? **ADVOCACY REPORT**

The European Union Institutions

Health continues to feature in EU development policy as a core element of human development. But the broadening of the 'Agenda for Change's' policy focus has led to serious concerns about the future of financial support to the health sector.

The European Union (EU) is a full member of the OECD-DAC and reports its development assistance as 'European Union institutions'.

Official Development Assistance (ODA) reported by EU institutions includes:

- Development spending that is part of the EU's general budget;
- The European Development Fund (EDF); and
- Interest subsidies to soften the terms of loans as well as trust funds administered by the European Investment Bank (EIB).[17]

The European Commission (EC), the Executive Body of the EU (comprising 28 Member States), manages the implementation of the EU's development budget and the EDF.

It has made significant changes to its ODA policy over the past two years. The new EU development policy, 'Agenda for Change', and its budget support policy, encapsulates a broader agenda than before and focuses on human development, democracy and governance as its key priorities.[18]

Health continues to feature in EU development policy as a core element of human development (alongside education, jobs and social protection). But the broadening of the 'Agenda for Change''s policy focus has led to serious concerns about the future of financial support to the health sector.

In July 2013, EU Member States and institutions came to a political agreement on the 2014-2020 Multi-annual Financial Framework (MFF), and are now negotiating detailed budgets that will implement the 'Agenda for Change' principles.

The major challenge will be to protect the Development Cooperation Instrument (DCI) at the current level of 17.4 billion euros, following the latest proposal by the EC.[19]

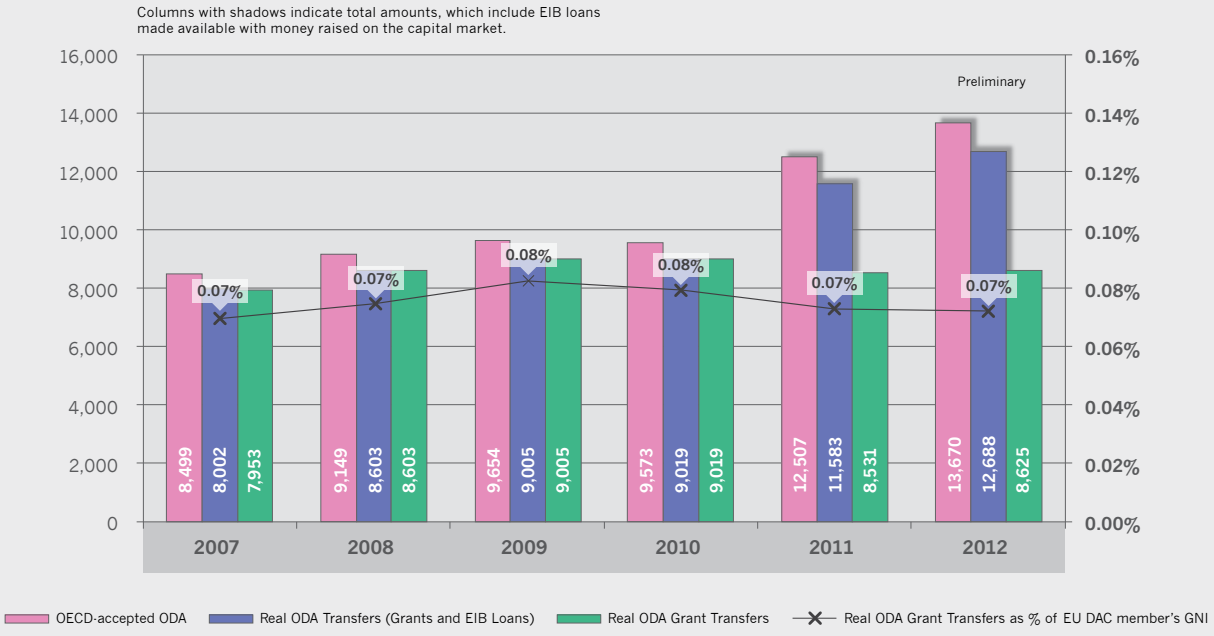
In addition, in light of the new EU development policy, it will be fundamental to ensure that at least 20% of all EU development aid [20] is earmarked for health and basic education.

According to accepted figures reported by the OECD, the EU institutions' total contribution to ODA in recent years steadily increased. This is from 8.5 billion euros in 2007 to 12.5 billion euros in 2011 and 13.7 billion euros in 2012. The biggest increase was in the period 2010-2011, from 9.6 billion euros in 2010 to 12.5 billion euros in 2011.

Total real ODA transfers experienced a similar increase in the period 2010-2011, passing from 9 billion euros in 2010 to 11.6 billion euros in 2011, and 12.7 billion euros in 2012.

However when we look at real grant transfers, we cannot see this increase. On the contrary we see a decrease from 9 billion euros in 2010 to 8.5 billion euros in 2011, then a tiny increase to 8.6 billion euros in 2012 (preliminary data).

Fig. 10



EU Institutions – Total ODA disbursements according to different approaches.
(Amounts in million euros and as a percentage of Gross National Income of EU DAC members)

Until 2011, EU institutions' contributions to total ODA included ODA grants (managed by the EC) and interest subsidies to soften EIB loans in developing countries. However, they excluded all loans and EU trust funds managed by the EIB.

This suggests an apparent increase of over 3 billion euros (equivalent to almost US$5 billion) in ODA from the EU institutions from 2010 onwards. But in reality, this is due to a change of definition in OECD reporting rather than an actual increase in EU ODA grants.

In our 2012 report, we applauded the EU institutions for their apparent [21] good practice of not including loans as ODA in the period 2007-2010.

This new shift in ODA reporting requirements and the DAC decision to include EIB loans as part of ODA from the EU institutions could be the start of a worrying global trend.

According to DAC Secretariat estimates, were it applied to all multilateral financial institutions, there could be a substantial (inflated) increase in overall aid volumes of around US$50 billion per year.

It will be fundamental to ensure that at least 20% of all EU development aid is earmarked for health and basic education.

TRENDS IN ODA FOR HEALTH

In last year's report, we noted a worrying trend. ODA for health from the EU institutions had dropped dramatically from 730 million euros in 2008 to 653 million euros in 2010. Contributions increased again to 700 million euros (in real grant transfers) in 2011. But they have still not been restored to their 2008 levels.

Compared with the other focus DAC donors in this report, EU institutions stand out as the donor that contributes the smallest proportion of total ODA to health (in real grant transfers), at 8.1%. However in 2011, ODA for health accounted for only 5.8% of Real ODA transfers, down from 7.3% in 2010.

This was due to three factors. They are:

* The figure includes loans, thus it reflects total ODA transfers;
* The new inclusion of EIB loans in ODA reporting; and
* The significant increase in total ODA, none of which went to health.

If we look at EU institutions' contributions by channel (Fig. 10), since 2007 the EU institutions have given the majority of ODA bilaterally.

The EC disbursed less ODA for health through General Budget Support (GBS) in 2011, due to challenges in implementing programmes in several African, Caribbean and Pacific Group of States (ACP) countries.[22] However, the EC increased its funding for bilateral health projects.

The Global Fund to Fight AIDS, TB and Malaria (GFATM) is the EU institutions' main recipient of multilateral health aid, receiving an average of 100 million euros. However, the amount disbursed by GFATM from the EU institutions in 2011 was 14 million euros less than the amount that was pledged.[23]

The GAVI Alliance (GAVI) received the second largest multilateral contribution for health in 2008 and 2009. But in 2010 and 2011, it received no support at all from the EU institutions.

Forecast and Outlook

The EU institutions' bilateral commitments for health reached its lowest level in 2011, compared with recent years. This makes it highly unlikely that disbursements for global health will increase in 2012. Nonetheless, the EU institutions have made significant pledges for global health in 2012.

These include around 264 million euros[24] to support maternal and child health as part of the 'MDG Initiative'; 23 million euros for family planning; US$12.5 million to GAVI; and a renewed bilateral partnership with Madagascar which includes a significant health component.

Civil society should monitor disbursements from EU institutions in the years ahead, and be prepared to hold EU institutions to account on their commitments.

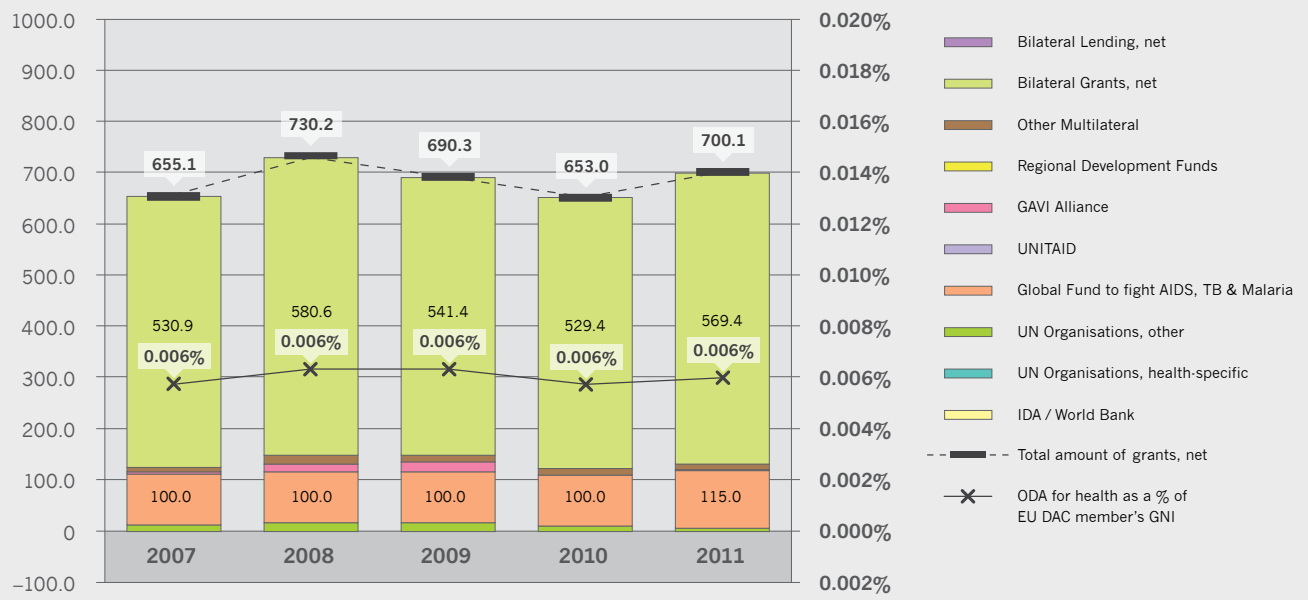
RECOMMENDATIONS

Financial Recommendations

* The EU institutions should protect the adjusted EC proposal of 17.4 billion euros for the DCI budget 2014-2020.
* The EU institutions should earmark at least 20% of the DCI to health and basic education; within the DCI, thematic and geographical programmes should be complementary to reaching this 20% benchmark.
* EU Member States and ACP partner countries should earmark at least 20% of funds under the 11th EDF for health and basic education.

The EU institutions' bilateral commitments for health reached their lowest level in 2011 (...). Nonetheless, the EU institutions have made significant pledges for global health in 2012.

Fig. 11



EU Institutions – Main components of ODA for Health in the period 2007-2011 (euro million).

Policy Recommendations

- Within the OECD-DAC debate on re-defining ODA, the EU institutions call for ODA definitions to remain targeted and specific. These must not be broadened to include all loans (of all multilateral financing institutions), and particularly those that are not "concessional in character" – the basis of the OECD's definition of aid.[25] [26]
- The EU should increase transparency and improve reporting of projects that include a health component to enable better tracking of the EU institutions' ODA for health (particularly under the 'Agenda for Change').
- The EU should ensure that health is a specific goal of the post-2015 development framework; this will contribute to mobilising sustainable funding in order to achieve the right to the highest attainable standard of health for all.

France

Since 2007, and up to 2010, France significantly increased the volume of its total ODA contribution, according to official OECD figures, as well as real ODA transfers. Real ODA transfers increased from 4,5 billion euros in 2007 to 7,1 billion euros in 2010, but declined to 6,7 billion euros in 2012.

However, grant transfers (within real transfers in ODA) did not increase significantly in this period. Grant-making has remained the same, which shows the increase is attributable to increased lending.

Real ODA grant transfers, as a proportion of GNI, have never risen above 0.3% and in 2012 was 0.29%. These figures are very different from France's contribution as reported by the OECD of 0.5% of GNI to ODA, which includes loans and non-transfer items.

The gross volume of loans more than tripled from 2007 (0.8 billion euros) to 2011 (over 2.8 billion euros). Loans added 0.08% of GNI to overall ODA in 2011.

After Japan, France transfers the highest volume of ODA in the form of loans among all DAC members. Between 2011 and 2012, loans accounted for over one third of real ODA (See AfGH ODA tracker tool for more information).

In 2010 and 2011, the French Government made a series of important commitments to global health.

These include:

* An additional 100 million euros annually for child and maternal health;
* An additional 60 million euros annually for the Global Fund; and
* An additional 100 million euros to GAVI for 2011-2015.

However, it is uncertain whether the new French Government, which came to power in May 2012, will be able to honour these commitments. The new Government has announced that development policy will be more closely aligned with economic and foreign interests. For the first time, a master law for development cooperation was debated in Parliament.

However, it will not be linked to financial targets, as was previously expected.

TRENDS IN ODA FOR HEALTH

Real ODA transfers for health increased slightly from 855 million euros in 2010 to 893 million euros in 2011. The share of ODA for health as a proportion of all ODA increased from 12.6% in 2010 to 13.4% in 2011.

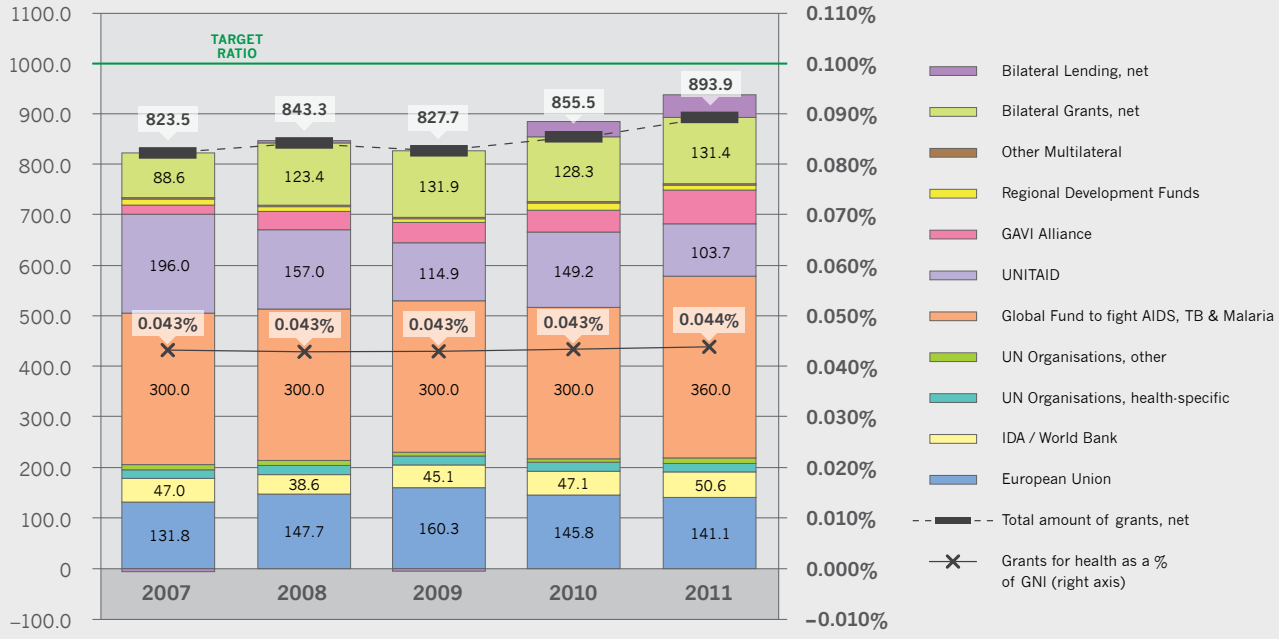
However, the contribution to health as a proportion of GNI remained stable at 0.043%, until 2010 and increased slightly to 0.044% in 2011. France is not yet halfway to WHO's recommended minimum 0.1% of GNI for global health. It is also failing to disburse funds to meet commitments made in 2010 and 2011 to global health.

If it is only counted in the form of grants, ODA for global health as a proportion of GNI remains stagnant from 2007 to 2011 at 0.043 - 0.044%.

Fig. 12

France – Total ODA disbursements according to different approaches.
(Amounts in million euros and as a percentage of Gross National Income)

Fig. 13



France – Main components of ODA for Health in the period 2007-2011 (euro million).

France is also failing to disburse funds to meet commitments made in 2010 and 2011 to global health.

However, bilateral loans in the health sector increased from 7 million euros in 2007 to 55 million euros in 2011. France is one of the few AfGH countries that disburses significant amounts of ODA for health in the form of loans.

Looking at preferred channels (see Fig. 12), multilateral organisations received the majority of France's ODA for health (80% in 2011).

Bilateral funding more than doubled in the period 2007-2011 (from 83 million euros to 176 million euros); however, this reflects increased bilateral loans and not grants in bilateral ODA for health.

If we look at multilateral ODA, the contribution to the Global Fund increased and a first contribution was made to GAVI in 2011. This was balanced by cuts to funding to UNITAID and the EDF.

The increase of the Global Fund contribution is directly related to the UNITAID decrease. Until 2011, 90% of the air tax levy was going to UNITAID and 10% to the IFFIm.

In 2011, the French Government decided that proceeds from the air tax levy would be split three ways, to include the increase to the Global Fund (of 60 million euros). Thus, UNITAID funding was reduced in order to accommodate the new beneficiary.

In 2011, France still did not fulfil commitments to its stated priority countries. In 2009, development policy stated that 14 countries would receive 50% of funding for MDG interventions, excluding multilateral contributions.[28] In 2011, only 30% of health grants were disbursed to those countries.

On a positive note, in 2011 France decided to accurately report contributions to UNITAID as multilateral funding. Since 2008, France had incorrectly reported UNITAID contributions as bilateral ODA, which distorted total bilateral contributions.

Forecast and Outlook

It appears likely that France will continue to fund ODA for health at the same level in 2012 and 2013. This works out as an average of around 850 million euros annually for the period 2007-2011.

Delivering on commitments is a challenge. In 2012, less than half of additional grants for maternal and child health were disbursed (19 million euros compared with 48 million euros pledged).[29]

Of the 100 million euros pledged to GAVI (2011-2015), only 67 million euros was disbursed between 2011 and 2013.

After two years of discussion and debate, in August 2012, France established a national Financial Transaction Tax (FTT) and announced 10% of revenue would be allocated to development. This should be upgraded to 15% due to less than expected revenues from the FTT but a willingness to keep the same volumes dedicated to ODA.[30]

Thus, in addition to traditional ODA budget lines, France will contribute 60 million euros to development. The Government also announced its intention to split this revenue in two: 50% to fund climate aid, and the remaining 50% for global health.

The funds (30 million euros) from FTT revenue in 2013 for global health will support free healthcare for children in Sahel countries. This can be seen as a translation of France's political commitment to support Universal Health Coverage (UHC).

France championed UHC at the UN General Assembly in December 2012,[31] and has stated that, together with efforts to eliminate HIV, TB and malaria, this will be a priority.

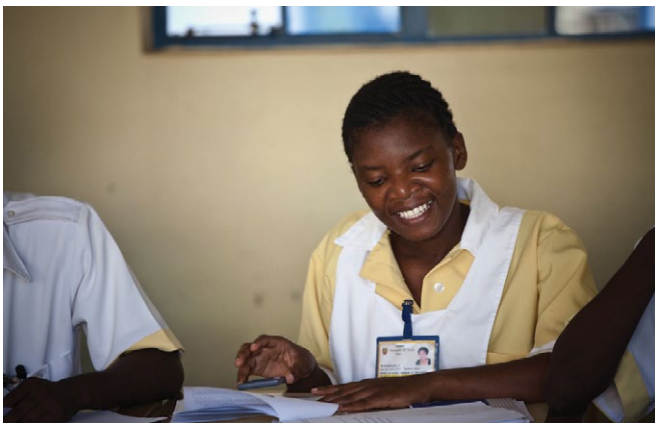
Any additional government financing is no longer on the agenda, and revenue from innovative financing will be used to compensate for cuts in the state budget.

With a decrease of more than 3% in ODA in 2014, the use of innovative financing will probably be essential. At best, it can offset the massive budget cuts; realistically innovative financing will not be additional. This approach is what civil society groups including AfGH see to be a 'zero sum game'.

French President, François Hollande announced France would maintain its contribution to the Global Fund of 1.08 billion euros for 2014-2016, especially through new revenues from the revaluation of the air tax levy (12.7%) and the FTT.

The use of FTT revenue and the Government's announcement to reallocate the air tax levy is likely to safeguard funding for global health in the coming years.

But any additional government financing is no longer on the agenda, and revenue from innovative financing will be used to compensate for cuts in the state budget.



Health funding is essential: a health training centre in Tete, Mozambique where there is only one doctor for every 30,000 people.

RECOMMENDATIONS

Financial Recommendations

- France should avoid the expansion of loans in the health sector.
- France should increase ODA in line with the French cooperation commitment by increasing the share of the FTT allocated for development, with a significant proportion for global health.
- France should fulfil existing commitments to ODA for health.

Policy Recommendations

- France should fulfil commitments for additional funding to the health sector, especially on UHC. This increase should not be made at the expense of other health priorities such as AIDS, TB and malaria.
- France should influence multilateral organisations (e.g. the International Development Association (IDA), the EC) to demand that health is prioritised and adequately funded.
- France should ensure that future programmatic law includes financial targets and strong accountability of financial commitments and development outcomes.

Germany

In 2013, Germany adopted an 'inter-ministerial concept on global health'. This is the first time all relevant government agencies have agreed on the basic understanding, values and direction of global health activities. How much the concept will have an impact on improving policy coherence remains to be seen.

Another positive development is that Germany released its annual contribution and made a new pledge to the Global Fund.

It also took up a seat on the Global Fund board, and welcomed a civil society representative to the Federal Ministry for Economic Development and Cooperation (BMZ) board delegation.

The Global Fund has been a hot topic since 2011 when the German Government publicly criticised it and froze its funding.

Although Germany has not so far been adversely affected by the Euro-crisis, German politicians and the general public are cautious about the economic environment.

However, in a representative poll almost three quarters (73%) of Germans agreed with revenues being used to honour Germany's international commitments on fighting poverty and climate change.[32]

This is a positive indicator of public opinion that could support the introduction of an FTT and the use of its revenues for fighting poverty.

A decrease in real ODA transfers in Germany from 8,705 million euros in 2011 to 8,542 million euros in 2012 marked an end to the annual increases that have occurred since 2007.

Germany is a solid performer in terms of ODA volume (third among DAC members). But relative to its economic capacity, it performs less well (tenth among DAC members).

In 2012, Germany contributed only 0.03% of GNI to ODA (real transfers), less than half its 0.7% of GNI commitment.

As is the case in France, lending accounts for an increasing proportion of Germany's ODA. Gross volume of lending reported as ODA more than doubled between 2007 and 2011 (preliminary figures for 2012 suggest a decrease in 2012 however).

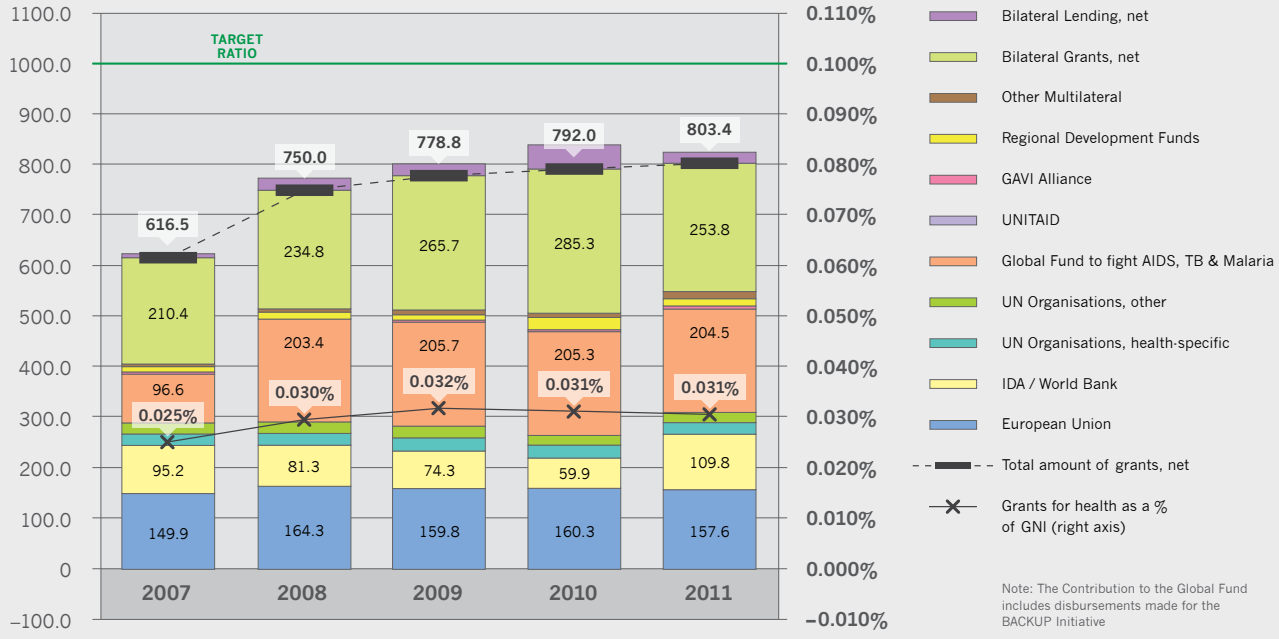
Germany's commitment to reduce multilateral engagement, at the same time increasing bilateral spending, is also starting to take shape. This shift in political thinking is affirmed in Germany's coalition agreement of 2009.

Given this orientation towards bilateral channels, it is important to note that in 2011, Germany invested only 35% of real bilateral ODA transfers in Least Developed Countries (LDCs) and Low-Income Countries (LICs) combined.[33] This contradicts its official focus on poverty reduction.

Fig. 14

Germany – Total ODA disbursements according to different approaches.
(Amounts in million euros and as a percentage of Gross National Income)

Fig. 15



Germany – Main components of ODA for Health in the period 2007-2011 (euro million).

Three quarters of Germans agree with revenues of an FTT being used to fight poverty and climate change.

TRENDS IN ODA FOR HEALTH

Germany contributed only 0.031% (real ODA transfers) of GNI to global health in 2011. This is far from WHO's recommended 0.1% of GNI to global health.

Germany's contribution to ODA for health increased from 2007 to 2010 in real ODA transfers as well as grant transfers, but declined in 2011. The proportion of ODA allocated to global health dropped to an unacceptable 9.4%, one of the lowest among the five AfGH countries.

This contradicts German development policy which states health is a priority sector. When we consider bilateral health ODA in 2011 only, the percentage is even lower at 6.4% (down from 9% in 2007).

Participation in the multilateral system is clearly essential to improving Germany's ODA levels. This is true, not only with respect to regional distribution, but also regarding the weight given to health as a vital area of human development.

It is in this context that the political intention of the former German Government to prioritise bilateral over multilateral cooperation has been a constant cause of concern.

The Conservative-Liberal Government was voted out in September 2013. It is hoped that the new government, without the Liberal Party which used to run the BMZ, will reverse this trend.

This is particularly important when we observe annual bilateral aid commitments of which, in the past two years of the study period, health represented only 4%.

In terms of distribution, while bilateral ODA for health is declining, multilateral ODA for health is increasing. This contrasts with the political plan and trend demonstrated across total ODA.

From 2010 to 2011, bilateral ODA for health decreased from 335 million euros to 277 million euros (in real transfers). But multilateral investments increased from 507 million euros in 2010 to 537 million euros in 2011.

So, it is only through multilateral increases that health remains a focus sector of German development cooperation. Disbursements to ODA for health in Sub-Saharan African countries remain about-constant compared with recent years.

These are still lower than might be expected given Germany's stated commitment to health, and the challenges posed by the morbidity and mortality figures in the region.

However bilateral funding programmes are negotiated with governments of recipient countries and reflect their focal areas. This calls into question the priority given to health in recipient countries, as well as by the German Government and its development agencies.

Multilateral contributions of ODA reflect a greater prioritisation of health. But this is still inadequate to meet commitments (including the MDGs) or respond to healthcare needs.

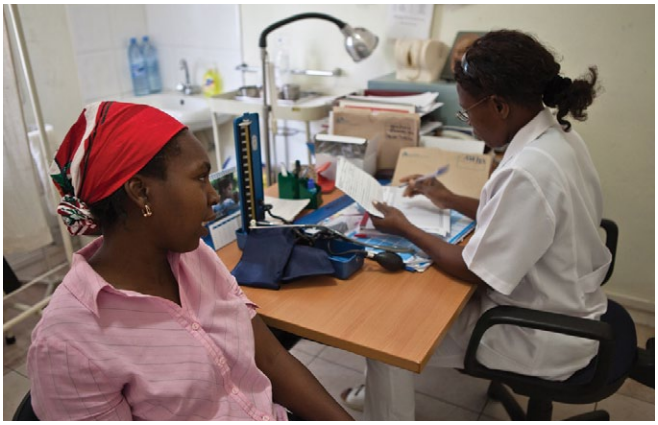
Participation in the multilateral system is essential to improving Germany's ODA levels and focus on poverty alleviation and health.

Forecast and Outlook

In 2011, Germany's bilateral commitments for health were significantly higher than in 2010. This may increase the relative share of ODA for health slightly, though it will still be insufficient to meet the 0.1% of GNI to health target.

Regardless of the exact composition and political direction of the new Government in Germany, health will likely remain a priority for German ODA, at least officially.

However, the Government's mid-term financial plan, which covers the period until 2017, paints a depressing picture for development. All ministries channeling ODA are, without exception, expected to make budget cuts. This makes the achievement of the 0.7% goal for ODA and the recommended 0.1% allocation for health even more unlikely to happen.



Family planning nurse Lucinda Lee with a patient at a clinic run by Mozambican NGO Amodefa.

RECOMMENDATIONS

Financial Recommendations

* Germany should honour its commitment to contribute 0.7% and 0.1% of GNI for total ODA and ODA for health, respectively.
* To that end, Germany should revise the mid-term financial plan and increase grant allocations to ODA, including ODA for health, within the 2014 budget.
* Germany should further push for the introduction of a Financial Transaction Tax (FTT) at EU level, and allocate a considerable share of its revenues to increase ODA for health.

Policy Recommendations

* Germany should re-establish a focus on poverty reduction and re-invest bilaterally and multilaterally in the health sector.
* The newly elected German Government should officially abolish the one third cap on multilateral ODA investments and establish sound criteria for ODA allocation.
* Germany should continue to play a constructive role in Global Fund policy debates, and reaffirm its leadership with increased financial support.

Italy

Italy has experienced a period of political uncertainty and transition in the last two years, which has only aggravated the severe financial and economic situation.

After Berlusconi's resignation in 2011, Prime Minister Monti's Government took steps to rejuvenate Italian development cooperation. This included the nomination of a Minister without Portfolio for International Cooperation and Integration.[34] [35]

The Monti Government lasted only 17 months. New elections were held in February 2013 and resulted in an unstable, coalition government led by the Democratic Party (of PD).

The new Government returned international cooperation to the Minister for Foreign Affairs, led by the former EU Commissioner Hon. E. Bonino. A Vice-Minister, Hon. Lapo Pistelli (PD) was charged with dealing with development cooperation.

For many years, when it comes to ODA, Italy has been one of the poorest-performing European DAC members in relation to its economic capacity.

In 2008, the peak year of the period under review, Italy contributed only 0.18% of its GNI to ODA (real transfers) to foster development in economically disadvantaged countries.

But even at this low level, Italy was already reducing real transfers of funds. Between 2008 and 2010, the volume of net ODA transfers fell from 2.7 billion euros to 2 billion euros. This represented a decline of more than 24% in nominal terms, bringing the contribution to ODA down to 0.13% of GNI.

In 2011, Italy increased its ODA contribution slightly to 2.22 billion euros, or 0.14% of GNI. However, 2012 data suggest that this increase was, at best, transitory.

Lending decreased from 2007 onwards, reaching an estimated low of 61 million euros in 2012. Italian development cooperation is still characterised by a high volume of non-transfer items, refugee costs and debt relief above all. In some years, non-transfer items created substantial differences between OECD-accepted figures and real financial efforts for ODA.

An analysis of the preliminary OECD data for 2012 shows that real ODA transfers fell to the lowest level seen since 2006 (1.9 billion euros or 0.12% of GNI). This trend must be reversed as a matter of urgency if Italy hopes to regain its role in the development arena.

TRENDS IN ODA FOR HEALTH

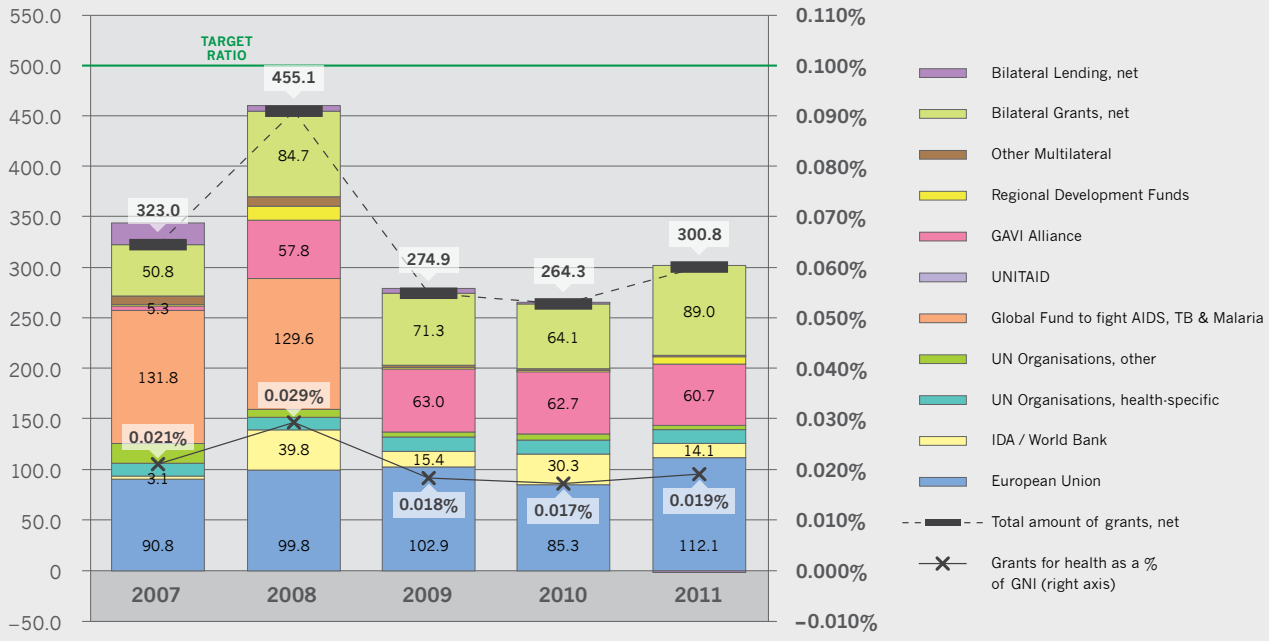
Italy's ODA contribution to global health increased by nearly 35 million euros from 2010 to 2011 (reaching 300.8 million euros). However, the contribution to health as a proportion of GNI is 0.019%, still a long way off the 0.1% of GNI contribution recommended by WHO.

This represents a three-year stagnation, and a contribution to global health that is far below the 2008 contribution (0.029% of GNI, or 455.1 million euros).

Fig. 16

Italy – Total ODA disbursements according to different approaches.
(Amounts in million euros and as a percentage of Gross National Income)

Fig. 17



Italy – Main components of ODA for Health in the period 2007-2011 (euro million).

Italy's contribution to ODA for health as a percentage on GNI is one of the lowest among DAC European countries.

Italy's contribution to ODA for health as a percentage of GNI is one of the lowest among DAC European countries.[36]

The share of health, as a proportion of all ODA, increased slightly from 13% in 2010 to 13.5% in 2011. Compared with other European donors this percentage is respectable, but it is still far from the 17.1% share reached in 2008.

One positive development in Italy is that bilateral ODA for health rose significantly in 2011, reaching 87 million euros.

Compared with 2008, the 'golden year' for global health, when the bilateral contribution to ODA for health was 90 million euros, this is not far off. However, this year it was still quite modest in volume.

Bilateral aid for health is almost exclusively provided through a very high number of small project-type interventions.

In 2011 alone, over 700 health-related aid activities were reported in the aid activity Creditor Reporting System (CRS) database. Of these, only 14 projects were for more than US$1 million, necessarily limiting impact and outcome.

Over two thirds of Italian ODA is disbursed through multilateral channels. This means ODA for global health will most likely not increase significantly until multilateral contributions do.

The main reason for Italy's poor performance in global health is due to the fact that it no longer contributes to the Global Fund.

In 2008, Italy channelled 130 million euros, about 28% of its ODA for health, through the Global Fund. Italy championed the Global Fund and, until 2008, was among its biggest contributors and held a seat on the board.

But from 2009, Italy disengaged: pledged contributions for 2009 and 2010 were never disbursed and no commitments were made for the period 2011-13.

As a result, Italy lost its role in the management and leadership structure of the Global Fund and is now represented only on the EU group seat (shared with Belgium, Finland, Portugal and Spain).

Multilateral channels, including the Global Fund, are the main vehicles through which Italy delivers ODA to priority, LICs.[37]

Therefore, without increasing multilateral ODA for health, Italy decreased drastically its total volume of health ODA. But it also substantially reduced health aid to its priority countries for development cooperation.

For instance, by cutting multilateral ODA, Italy reduced the aid it delivered to ten priority Sub-Saharan African countries from US$104 million in 2008 to just US$62 million in 2010, a cut of 40%.[38]

Forecast and Outlook

Italy's 2012 contribution to ODA for health is not yet published. However, its total contribution to ODA in 2012 was at its lowest level since 2007 (1.9 billion euros in real transfers, or 0.12% of GNI). It therefore seems likely that ODA for health will also have declined.

The Government's economic and financial plan 2014-2017,[39] approved by the Council of Ministers in April 2013, suggests a new emphasis on development cooperation in the coming years.

If implemented fully, the plan will lead Italy to contribute 0.3% of GNI to ODA in 2017. While this is still far from achieving the 0.7% of GNI commitment, the plan is a serious effort to realign Italy with international standards of development cooperation.

The next Global Fund replenishment is a concrete opportunity for Italy to demonstrate that it is a serious player in the field of global health.

The plan will not be achieved without an increase in aid for global health. Italy has little capacity to implement major bilateral interventions. Therefore, multilateral institutions are ideal recipients both to efficiently implement Italian ODA and to reach priority LICs.

The next Global Fund replenishment, at the end of 2013, is a concrete opportunity for Italy to demonstrate that it is a serious player in the field of global health and international cooperation.

In July 2013, Italy expressed interest in resuming support for the Global Fund.[40] A parliamentary motion was made in response.[41] The motion emphasised that if Italy does not make a strong commitment at the next replenishment meeting of the Global Fund, the country will lose credibility and suffer the political consequences.

RECOMMENDATIONS

Policy Recommendations

* The Italian Government should act immediately to realign Italian ODA, especially for global health, with international standards, as stated in the 'Documento di Economia e Finanzia (DEF) 2014-2017' (approved in April 2013).
* The Government should scale up contributions to reputable and effective multilateral development institutions, particularly in the health sector. This will be a means of achieving the financial and policy target of the Italian development cooperation strategy.

Financial Recommendations

* The Italian Government should fulfil its commitments to respond to global health epidemics. As a first step, it should declare a financial commitment to the Global Fund, on the occasion of the final session of the 4th Replenishment Conference, amounting to 100 million euros per year for the period 2014-2016.
* The Government should accompany its financial commitments with political commitment and a role in the governance structure of the Global Fund, with a particular focus on monitoring and influencing decisions about national health systems.

Women queue outside a remote health centre in Tsangano, Mozambique, a country which relies heavily on ODA to fund its health system.

The Netherlands

The Netherlands decreased ODA for global health from 0.102% of GNI in 2009 to 0.081% in 2011. Although it is still above average, the Dutch trend is discouraging

In October 2012, a new coalition government came to power in the Netherlands and with it many internal challenges and conflicts. The rightist Liberal Party (VVD) and the Social Democratic Party (PvdA), which make up the Government, hold conflicting views on development cooperation. The VVD is in favour of a US$3.9 billion (3 billion euros) cut to ODA and the PvdA proposes maintaining at least a 0.7% of GNI contribution to ODA.

Encouragingly, the new Cabinet has upgraded the position of State Secretary for Development Cooperation to the position of Minister for Foreign Trade and Development Cooperation. The Minister participates in weekly ministerial councils and is tasked with increasing policy coherence for development.

As such, the Minister will be responsible for working with other ministries to change and update their policies so that they support, and do not conflict, with development cooperation policy.

Despite these positive institutional changes, between 2013 and 2017 the Government plans to cut the development cooperation budget from 0.7% of GNI to 0.55% of GNI.

In addition, the Coalition has decided that disbursements to address climate change, and 250 million euros annually for military expenditure, will come out of the ODA budget. It remains to be seen what little will be left for traditional development interventions, including in the health sector.

The Netherlands maintained the 0.7% of GNI target for development cooperation according to OECD-accepted figures of ODA. However, the OECD-accepted ODA ratio still fell significantly from 0.81% in 2009 to 0.71% in 2012.

On the other hand, when considering only grant transfers, ODA as a percentage of GNI fell well below the 0.7% target, to 0.6% in 2012[42] from 0.74% in 2009.

In terms of volume, real ODA transfers decreased from more than 4.3 billion euros in the peak year of 2008 to about 3.6 billion euros in 2012. This represented a decline of 17% over this five-year period.

TRENDS IN ODA FOR HEALTH

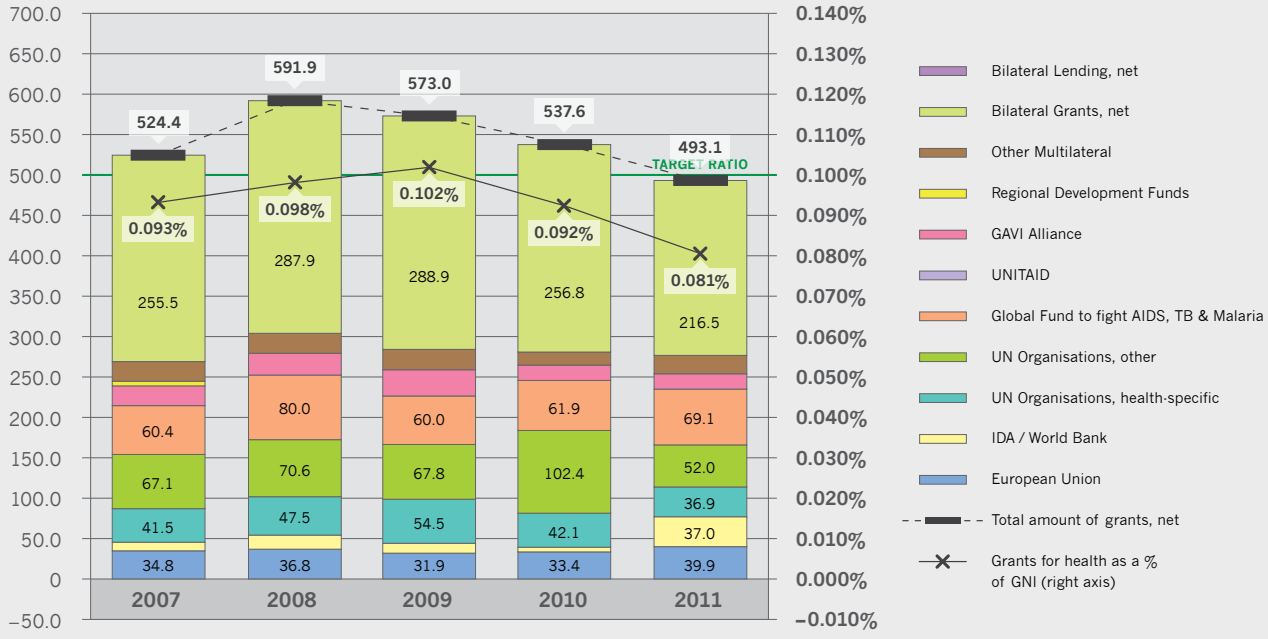
In 2009 the Netherlands reached the WHO-recommended 0.1% of GNI contribution to global health. But the Dutch Government reduced ODA contributions for health to 0.092% of GNI in 2010, and then to 0.081% in 2011.

In terms of absolute volumes, the Netherlands' contribution to foster global health peaked in the year 2008, reaching nearly 600 million euros. The overall ODA contribution for health declined in every consecutive year after that at an ever-faster rate. It finally fell to 493 million euros in 2011. Cumulatively, this represents a decrease of one fifth of its original magnitude.

Fig. 18

The Netherlands – Total ODA disbursements according to different approaches.
(Amounts in million euros and as a percentage of Gross National Income)

Fig. 19



The Netherlands – Main components of ODA for Health in the period 2007-2011 (euro million).

‘Aid for trade’ is the new paradigm in the Netherlands. While this is being presented as a solution to the economic crisis, it risks marginalising global health and could have a profound impact on development and trade.

Regarding the main financing mechanisms, ODA for health continues to be fairly balanced between bilateral and multilateral channels. From 2010 to 2011, bilateral contributions for health through GBS almost halved, from 13 million euros to 7 million euros. Support for bilateral health projects in the same period decreased by more than 12% (from 257 million euros to 216 million euros).

2011 also saw a significant decline in the share of health ODA as a proportion of total ODA transfers. This accounted for roughly 12% compared with 14% in previous years.

In line with the new policy to support trade and private sector involvement, 2011 marks a shift away from support to UN institutions.

Contributions to UNAIDS, UNDP, UNFPA and UNICEF have been drastically reduced and diverted towards the World Bank, which is now among the primary recipients of multilateral total Dutch ODA and ODA for health.

Dutch ODA for health that is channelled through the International Development Agency (IDA) of the World Bank rose dramatically from 6 million euros in 2010 to 37 million euros in 2011, although this could partly be the effect of delays in the disbursement schedule.

In previous years, among the focus AfGH countries, the Netherlands was the best performer in terms of quality of ODA for health, since all its ODA in the sector was in the form of grants.

In 2011, this situation has not changed. However, the new Minister for Development Cooperation and Trade has introduced the ‘Dutch Good Growth Fund’ to stimulate private sector growth in LICs and MICs.

This new fund offers loans to entrepreneurs with investment plans that are relevant for socially responsible and sustainable development. The Dutch Good Growth Fund should be closely monitored to make sure these loans are additional and do not replace existing grants. Investments through the Fund should also complement Dutch commitments to ODA for health.

Forecast and Outlook

The forecast in terms of bilateral and multilateral ODA for health based on figures for 2011 and 2012 looks even bleaker.

The main reasons are:

* A fall in the contribution to the Global Fund from US$88 in 2011 to US$31 million in 2012 [43] (the pledge for 2013 came close to the 2011 level, but no payment was made in the first half of this year);
* The extraordinarily low volume of new bilateral commitments totalling less than 100 million euros.

The foreseeable negative trend is compounded by the fact that the contribution to the IDA/World Bank fell again from the very high level seen in 2011. Disbursements started to the IFFIm,[44] amounting to US$19 million in 2012 and US$20 million in 2013. However this, combined with a simultaneous decline in direct annual contributions, will not be enough to compensate for the afore-mentioned cuts.

‘Aid for trade’ is the new paradigm in the Netherlands. While this is being presented as a solution to the economic crisis, it risks marginalising global health and could have a profound impact on development and trade.

In February 2013, the Dutch Advisory Council on International Affairs stressed the importance of global health as enabling a well-functioning economy:

“Development strategies aimed at poverty reduction should focus on all of these dimensions that are to be effective. A sound economy cannot function without healthy, well-trained people”.[45]

Development strategies aimed at poverty reduction should focus on all of these dimensions that are to be effective. A sound economy cannot function without healthy, well-trained people.

For long-term impact and sustainability, the focus on trade and private entrepreneurship must have a comprehensive approach that includes, above all, global health.[46]

Innovative financing mechanisms, such as the FTT, are subject to fierce discussions between the Dutch Cabinet, banks and pension funds. The FTT offers promising opportunities for raising new revenue, in the context of decreasing budgets. But it seems unlikely that the Netherlands will adopt it soon.

RECOMMENDATIONS

Financial Recommendations

* The Dutch Government should contribute at least 0.7% of GNI as ODA real grant transfers, including 0.1% GNI for global health, not including expenditure for international climate or military efforts.
* The Ministry of Foreign Trade and Development Cooperation should monitor performance of the Dutch Good Growth Fund and be transparent about whether loans are additional and do not replace existing grants.
* The private sector should be obliged to co-finance a substantial part of Dutch climate funding (as stated by the leader of the Social Democratic Party).

Policy Recommendations

* The Dutch Government should be explicit about the role of public health in stimulating inclusive economic growth and as a good way to approach development issues in a time of economic crisis.
* However, it is very important to realise the pre-conditions for a well-functioning trade climate, with global health as a main priority. There is a strong causality between health and economic growth. Health is crucial for sustainable human development, both as an individual right and an essential contributor to the economic growth of a society.
* The Netherlands should approach global health as a Global Public Good (GPG) with border-crossing consequences, and support global health as a top priority in the post-MDGs development framework. The Cabinet strongly expressed its support for the Sustainable Development Goals (SDGs). The Dutch Government should continue to champion a comprehensive approach to the SDGs and a greater focus on global health.

Health and education in India: The Dutch government should be explicit about the role of public health in stimulating economic growth.

Spain

Spain made significant efforts to increase its ODA contribution from 2007 to 2009, and thus progressed towards internationally-agreed commitments for financial cooperation for development. However, in the last two years Spain has made the deepest cuts in ODA seen in any country in recent history.

The shift in development cooperation policy was brought in by the Conservative Government, which came into power in 2011. It has aligned development cooperation with the country's foreign policy and economic interests.

As part of this re-alignment, the Government redefined its relationship with civil society and re-invigorated the role of the private, commercial sector in development.

Although most DAC countries have reduced the volume of their contributions to ODA for 2012, Spain has made the most extensive cuts. It cut real ODA transfers by over 50% (1.4 billion euros, equivalent to US$2.1 billion), compared with 2011.

Spain's contribution relative to economic capacity dropped from 0.26% of GNI in 2011 to 0.13% of GNI in 2012. This puts Spain at the bottom of the 24 DAC donors, together with Greece, Italy, Portugal and Korea.

Decentralised cooperation, a distinctive feature of Spanish development cooperation, has plummeted since 2008. The collective autonomous regions' ODA contribution has decreased from 0.27% of their total budget in 2008 to a forecast of 0.09% in 2013.

The Government cut bilateral ODA considerably more than multilateral ODA. Real bilateral ODA transfers in net terms provided directly to recipient countries fell from more than 2.9 billion euros in 2009 to around half a billion euros in 2012.

ODA funds channelled through international organisations decreased from 1.5 billion euros to approximately 0.86 billion euros in the same period.

Thus, the proportions disbursed through these channels reversed. The share of bilateral transfers fell from 66% in 2009 to 36% in 2012, whereas the percentage of multilateral ODA flows grew from 34% to nearly 64% in those years.

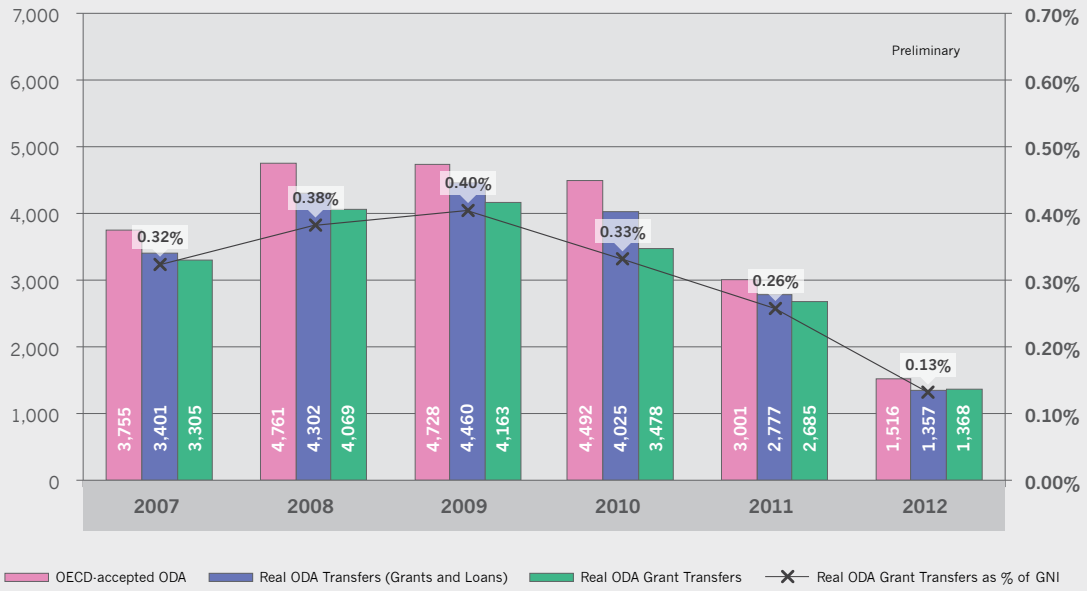
Bilateral core contributions and pooled programmes and funds, which include core funding of NGOs, were reduced from 960 million euros in 2010 to just over 140 million euros in 2012.

General and sector budget support virtually disappeared, as these funding streams combined fell from close to 200 million euros to only 16 million euros in two years.

TRENDS IN ODA FOR HEALTH

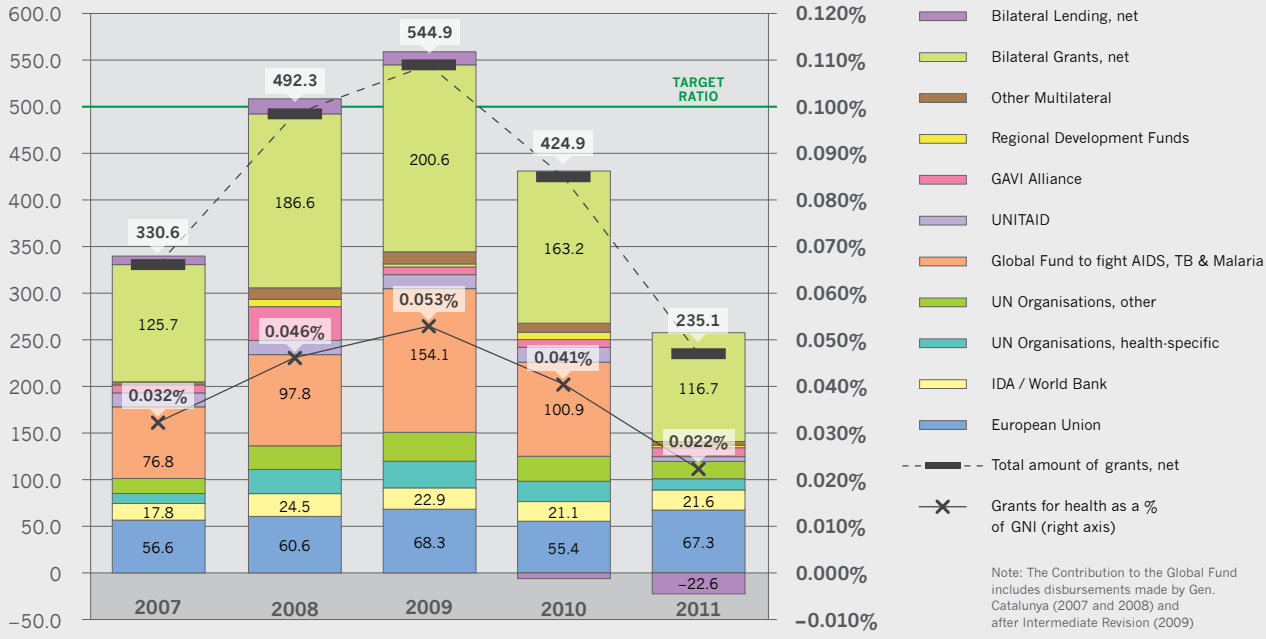
As the Government has implemented cuts to ODA, health has occupied an increasingly smaller share of total ODA. Data for ODA for health is not yet available for 2012, but in 2011 ODA for health was cut by 190 million euros (or US$236 million). This is a cut of almost 45% from 2010.

Fig. 20



Spain – Total ODA disbursements according to different approaches.
(Amounts in million euros and as a percentage of Gross National Income)

Fig. 21



Spain – Main components of ODA for Health in the period 2007-2011 (euro million).

Since 2009, the Spanish Government continues to make deep cuts. ODA for health has suffered disproportionately (around 50%) in relation to total ODA.

ODA for health represented only 8.5% of total ODA in 2011, compared with 10.6% in 2010. Against the WHO recommendation of 0.1% of GNI to global health, Spain's contribution of 0.022% of GNI is very low, and down from the 0.052% reached in 2009.

In addition, Spain's contribution to global health is at odds with public statements about global health. High-level officials and politicians, linked to and responsible for development cooperation, continue to reaffirm the fundamental importance of global health, as do key development strategies and policies.

Furthermore, according to an opinion poll by UNICEF and the Bill and Melinda Gates Foundation (BMGF) in 2012, 74% of Spanish people are in favour of maintaining Spain's commitments to international cooperation.

Health ODA channelled through multilateral agencies fell from 344 million euros in 2009 to 141 million euros in 2011. While Spain used to be one of the top ten donors to the Global Fund, in 2010 it disbursed little more than half of its pledge (US$101 million), and did not make any contribution in 2011 or 2012.

In addition to cutting contributions to health-related UN organisations such as UNDP, UNFPA, the World Food Programme (WFP) and WHO, Spain is also late in transferring funds. A total annual amount of US$14.8 million was due to WHO in 2011. But the main part of US$11.5 million was not paid until September 2012, while the entire contribution for 2012 was only transferred in February 2013.

Since 2009, the Government continues to make deep cuts also in bilateral ODA for health. This is a trend that has occurred every year since 2009, when health bilateral ODA was 215 million euros falling to 94 million euros in 2011.

Forecast and Outlook

In recent years, ODA for health has suffered disproportionately large cuts (around 50%) in relation to total ODA. Contributions for 2012 (to total ODA and global health) are therefore likely to be dismal.

The planned allocation to health in 2012 was 124.45 million euros, according to preliminary data from the General Secretariat for International Cooperation for Development (SGCID). But of this, only 74 million euros have been disbursed, 40% less than planned.[47]

Although multilateral partners have played an important role in fulfilling Spain's commitments to ODA for health in the past, it seems unlikely that funding will be renewed. In particular, Spain is unlikely to make any financial commitments to the Global Fund for 2014-16.

In 2013, the Government made changes to legislation and policy that will have a lasting impact on Spanish cooperation. Until now, Spain has been unique among (most) DAC donors in that different regions have held their own development cooperation budgets.

This has been one of the most distinctive and positive elements of Spanish development cooperation. However, the 2013 Local Administration Reform Law will make it almost impossible for local administrations to maintain their own development cooperation budgets.

Another worrying trend is the increase in the proportion of ODA assigned to the Fund for the Promotion of Development (FONPRODE),[48] a new pillar of development cooperation.

Funds disbursed through FONPRODE mainly take the form of loans. FONPRODE's 2013 budget accounts for 18.8% of planned ODA. This is a modest decline of just 10.9% (245 million euros) from 2012, compared with other ODA channels. As a result, it is likely that loans will represent over 5% of ODA in 2013.

Spain has been unique among DAC donors in that different regions have held their own development cooperation budgets.

Although the Government indicated its intention to at least maintain the current level of ODA in the 2014 national budget, we are going to see further cuts. According to the general state budget for 2014 submitted by the Government to Parliament, ODA will be 1.814,98 million euros, down 234 million euros from 2013. Although the budget will have to be approved by Parliament, it is highly unlikely this figure will increase in view of the overall majority of the Conservative Party.

As one of the 11 signatory states to the EU FTT, Spain is set to introduce the FTT in 2014, which could be a source of additional funding for development cooperation. However, it is not clear whether the Government will allocate revenues to ODA, in general, and health ODA, in particular.

RECOMMENDATIONS

Financial Recommendations

* The Spanish Government should increase ODA contributions for global health in line with the Spanish development cooperation commitment to the health sector. The Government must reaffirm the goal of 0.1% of GNI to the health sector for development cooperation.
* Spanish cooperation should fulfil its pledge of 2012 to contribute 10 million euros to the Global Fund as a first step to re-engaging with the Fund.

Policy Recommendations

* Spanish officials have made strong policy statements for global health, but these policies must be supported with financial commitments if Spain is to regain its role in the development arena and specifically in global health.
* The Spanish Government should commit to allocating part of the revenue from the FTT to Global Public Goods (GPGs), including health and the fight against climate change.
* The Government should strictly comply with FONPRODE rules and regulations that limit the percentage of ODA disbursed as loans to 5%.

Healthcare in El Salvador: Spain must reaffirm its commitment of 0.1 per cent of GNI to the health sector.

The United Kingdom

In the past three years, the UK Government has reaffirmed its prioritisation of international development. It has convened three international summits – on immunisation, family planning and hunger – and 'ring-fenced' the international development budget, despite the global economic downturn.

In recognition of the UK's championing of international development, the UN Secretary-General Ban Ki-moon appointed Prime Minister David Cameron to co-chair the High Level Panel on the Post-2015 Development Agenda, with President Susilo Bambang Yudhoyono of Indonesia and President Ellen Johnson Sirleaf of Liberia.

The UK contributed 0.54% of GNI, or £8,334 million, to ODA (in real transfers) in 2012 and, according to budget plans, is on track to deliver 0.7% of GNI as ODA from 2013.[49] [50]

In doing so, the UK will be the first of the G8 countries to meet this long-standing commitment. It will be a positive step forward. Although the UK contribution to ODA increased from 2007 to 2010, since then the contribution has remained the same at about 0.5% of GNI.

In recent years, the Government has consistently stated that it is wrong to use the economic downturn as an excuse for failure on development commitments.[51] [52] [53]

The UK is unique among the focus AfGH countries in that it includes a comparatively small volume of loans and non-transfer items in its reporting of ODA to the OECD.

Non-transfer items, and mainly administrative costs within the UK, account for approximately 0.02% of GNI.

Loans represented just 0.01% of GNI (net volume of about £200 million), for most of the years included in the data analysis. Lending included in ODA reporting refers almost exclusively to equity investments,[54] and these have increased in the last two years.

The UK has maintained its opposition to taxing the financial sector for development cooperation (or other social causes) on the grounds that an FTT would have a negative impact on the UK economy.

In April 2013, the UK Government launched a legal challenge against the EU's plans for a European FTT. However, as accounting firm KPMG has noted:

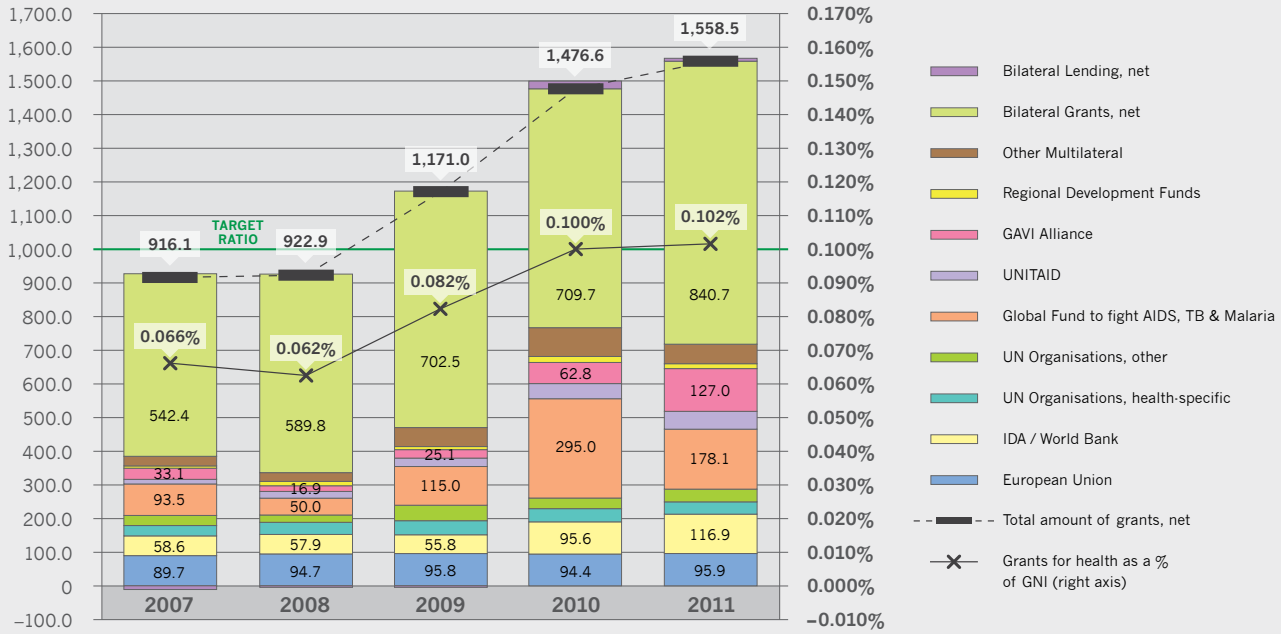
"The UK legal challenge is very unlikely to derail negotiations amongst the EU11 or the timing of the introduction of the FTT."[55]

Recent legal opinion has concluded that under article 178 of the European Treaty, the legal challenge is unjustifiable, since the FTT is not yet in force. The British financial journalist Larry Elliott, writing in the Guardian, sums up the present situation:

Fig. 22

United Kingdom – Total ODA disbursements according to different approaches.
(Amounts in million euros and as a percentage of Gross National Income)

Fig. 23



United Kingdom – Main components of ODA for Health in the period 2007-2011 (euro million).

The UK is one of the best European performers on ODA and delivered on its commitment to 0.7% of GNI for ODA in the 2013-2014 budget. Legislation to enshrine the 0.7% commitment in law would ensure it remains so.

"Reports of the death of the FTT look exaggerated. The City is engaged in a damage limitation exercise."[56]

The UK is one of the best European performers on ODA and delivered on its commitment to 0.7% of GNI for ODA in the 2013-2014 budget. Legislation to enshrine the 0.7% commitment in law would ensure it remains so.

TRENDS IN ODA FOR HEALTH

While UK contributions to ODA for health remained the same between 2007 and 2008, they have increased annually since 2008, with 2011 representing a 9% increase from 2010.

This meant the UK reached, in 2010, the international recommendation of providing a minimum of 0.1% of GNI to global health. In 2011, the UK contributed £1,558 million in ODA for health, which accounts for 18.7% of the total ODA.

The UK is by far the best performer in global health among AfGH focus countries and, according to 2011 preliminary data, even when compared with other well-performing European countries such as Denmark, Norway and Sweden.

The UK balances its ODA contributions for health between multilateral (45% in 2011) and bilateral channels (55% in 2011). This distribution has been fairly balanced since 2007.

As part of its agenda to achieve 'value-for-money' and transparency, the Government commissioned comprehensive spending reviews of both bilateral and multilateral ODA in 2010. The outcome of the Bilateral Aid Review has been focused on ending aid to MICs and having a smaller group of priority countries for UK aid.

The Multilateral Aid Review found that among multilateral agencies, GAVI, the IDA/World Bank and the Global Fund were most efficient and effective.[57]

Unsurprisingly therefore, the largest multilateral disbursements in 2011 were to the Global Fund (£149 million), the World Bank/IDA (£117 million) and the EU (£96 million). The contribution to GAVI increased by £41 million in 2011 (to £51 million), in parallel with a major conference on vaccination hosted by the UK.

In September 2013, UK Secretary of State for International Development Justine Greening announced a UK commitment of up to £1 billion for the 2014-2016 replenishment of the Global Fund.

The UK will deliver the full commitment of £1 billion if other donors make sufficient commitments to ensure that the Global Fund reaches its replenishment target of US$15 billion.

Forecast and Outlook

In early 2013, the UK Government announced its intentions for the Department for International Development (DFID) to work more closely with the Ministry of Defence (MOD) and Foreign and Commonwealth Office (FCO). This could result in the development budget being reallocated to other international relations interventions at the expense of traditional development sectors, including health.

The Government is expected to continue its policy of ending aid programmes in MICs, such as India and South Africa, "to focus aid where it is needed most."[58]

This policy is controversial since more than 70% of the world's poorest people live in MICs. It remains to be seen whether ending such programmes will be coherent with the UK's policy of poverty reduction.

The Government is expected to continue its policy of ending aid programmes in middle-income countries. This policy is controversial since more than 70% of the world's poorest people live in middle-income countries.

Civil society will be looking to the Government to fulfil its election manifesto to enshrine the 0.7% of GNI commitment to ODA in law. This would protect the aid budget from political change and ensure greater accountability by the Government to the UK general public on how aid is spent and the quality of aid outcomes.

The UK is ending aid programmes in Middle-Income Countries (MICs) like India. Seventy per cent of the world's poorest people live in MICs.

RECOMMENDATIONS

Financial Recommendations

* The UK Government should reconsider implementation of an FTT and allocate a significant part of FTT revenues to development and global health.

Policy Recommendations

* The UK Government should fulfil its election promise of enshrining the 0.7% of GNI commitment to ODA in law.
* The UK Government should ensure that its ODA includes only interventions that contribute directly to development goals. Expenditure on defence or peace-keeping must be reported separately.
* The UK Government should champion the inclusion of the 0.7% of GNI commitment to ODA in the post-2015 development framework.
* DFID should attempt to address the heaviest burdens of disease and ill-health regardless of where they are found, moving from a pure value-for-money agenda to one which incorporates a focus on the poorest and most marginalised.

Endnotes

1 World Health Organisation, Commission on Macroeconomics and Health, 2006. Tough choices: Investing in health for development.

2 World Health Organisation, Global Health Observatory. Available at www.who.int/gho

3 http://whqlibdoc.who.int/publications/2001/924154550x.pdf

4 http://stats.oecd.org/

5 See section on methodology pages 10-12.

6 The preliminary data published by OECD-DAC for 2012 does not provide figures for imputed student costs and costs for refugees. Thus, in order to calculate real and grant transfers for 2012, these indicators were calculated for all DAC members using data of previous years in the respective national currencies and applying the exchange rates corresponding to 2012. When data were lacking for other indicators in the case of single donor countries a similar procedure was applied. This refers to transfers in the form of loans for France and administrative costs for Switzerland. It is important to note that reported figures may change considerably when final data become available, as the experience for the year 2011 demonstrated (when we observed significant differences between preliminary data and final data published later).

7 First agreed in 1970, and reaffirmed most recently in 2012, today's EU Member States have committed to contribute a tiny proportion of their overall budgets – 0.7% of Gross National Income (GNI) – to support international development. Available at http://stats.oecd.org/Index aspx?datasetcode=TABLE1

8 http://stats.oecd.org/Indexaspx?datasetcode =TABLE1

9 See for instance article by Richard Manning, Financial Times, April 9, 2013, available at http://www.ft.com/intl/cms/s/0/b3d73884-a056-11e2-88b6-00144feabdc0.html#axzz2hy8X4qSJ

10 Although this issue on loans raised on capital markets requires further research, preliminary findings from AfGH and the MMI show that in the case of Germany, more than 50% of loans are coming from capital markets.

11 Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxemburg, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland and the United Kingdom.

12 Calculation of grant transfers in the case of 2012 for France had to be based on the trends seen in the previous years (2009-2011), because concrete figures of ODA loan flows were not yet published by OECD.

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14 The target set in the UNAIDS Political Declaration of June 2011 is 15 million people.

15 Ministry of Health, Kenya, 2009. Household Survey of Health Care Utilisation and Expenditure in 2007.

16 Forsyth, J. 2013. Time for universality to reduce inequity, The Lancet, Volume 382, Issue 9899, pp1161-1162. Available at http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)61722-5/fulltext

17 Organisation for Economic Cooperation and Development, Development Cooperation Directorate, Development Assistance Committee (2013). Converged Statistical Reporting Directives for the Creditor Reporting System (CRS) and the Annual DAC Questionnaire – Addendum 1 – Annexes – modules A, B, and C. Available at http://www.oecd.org/dac/stats/documentupload/DCD-DAC%282013%2915-ADD1-FINAL-ENG.pdf

18 European Commission, DG Development and Cooperation – EuropeAid (2011). Agenda for Change. Available at http://ec.europa.eu/europeaid/news/agenda_for_change_en.htm

19 Council of the European Union, 2013. Multi-annual Financial Framework (2014-2020) – List of programmes. Available at http://register.consilium.europa.eu/pdf/en/13/st08/st08288.en13.pdf

20 The data presented in this report refer to the total and global health ODA contributions by EU institutions. However, the term 'EU development aid' refers only to the Development Cooperation Instrument (DCI) and the European Development Fund (EDF).

21 'Apparent' because the EU institutions aimed to have EIB loans included in their ODA reporting from 2008. In fact, they only managed to have these loans included as part of their ODA from 2011.

22 European Commission (2012). Annual Report 2012 on the European Union's Development and External Assistance Policies and their Implementation in 2011. Available at http://ec.europa.eu/europeaid/multimedia/publications/documents/annual-reports/europeaid_annual_report_2012_full_en.pdf

23 The Global Fund to fight AIDS, Tuberculosis and Malaria, 2013. Core Pledges and Contributions. Available at http://www.theglobalfund.org/en/donors/public/

24 Based on calculations from EC press releases. Note that in Malawi, Rwanda and Zambia, MDG Initiative programmes include support towards MDG 1. For more information, see: EUROPA Press Releases Rapid (2011) Millennium Development Goals: EU gives additional support to 36 countries for tackling major development challenges. Available at http://europa.eu/rapid/press-release_MEMO-11-930_en.htm

25 AfGH plans to carry out a broader analysis of loans by the end of 2013.

26 See also article by Richard Manning, Financial Times at http://www.ft.com/cms/s/0/b3d73884-a056-11e2-88b6-00144feabdc0.html

27 Décret n° 2011-1237 du 4 octobre 2011 portant modification du décret n° 2006-1139 du 12 septembre 2006 sur le fonds de solidarité pour le développement.

28 CICID Juin 2009 - taken from conclusions http://www.diplomatie.gouv.fr/fr/politique-etrangere-de-la-france/aide-au-developpement-et/dispositifs-et-enjeux-de-l-aide-au/institutions-francaises/le-dispositif-institutionnel/article/cicid-juin-2009

29 Figures taken out of a communication from the health unit of The Development Agency.

30 Financial Bill, 2013. Source: Projet annuel de performances 2013 – Aide publique au developpement http://www.performance-publique.budget.gouv.fr/farandole/2013/ pap/pdf/PAP2013_BG_Aide_publique_developpement.pdf

31 UN General Assembly Resolution A/67/L.36.

32 http://infogr.am/So-denken-die-Deutschen-ber-die-Steuer-gegen-Armut/

33 Data from AfGH and MMI analysis for 2010 and 2011.

34 See the AfGH 2012 ODA Policy Report, Results or Rhetoric? What you didn't know about Europe's Aid for Health. Available at http://www.actionforglobalhealth.eu/fileadmin/AfGH_Intranet/AfGH/ODA/oda_singles.pdf

35 Ibid.

36 After Greece, Austria and Portugal.

37 These are ten countries in Sub-Saharan Africa: Burkina Faso, Ethiopia, Guinea, Kenya, Mozambique, Niger, Senegal, South Sudan, Sudan, Somalia; two in North Africa: Egypt, Tunisia; one in the Balkans: Albania; three in the Middle East: Iraq, Lebanon, Palestine Territories; four in Latin America: Bolivia, Cuba, Ecuador, El Salvador; four in Asia and Oceania: Afghanistan, Myanmar, Pakistan and Vietnam.

38 These figures could be visualised through our interactive ODA tracker tool http://www.actionforglobalhealth.eu/index.php?id=311

39 Documento di Economia e Finanzia (DEF) 2014-2017. Available at http://www.mef.gov.it/doc-finanza-pubblica/def/2013/documenti/DEF_1_-_PdS_2013_xon-linex.pdf

40 On 18 July 2013, the President of Italy's Chamber of Deputies (Laura Boldrini) said Italy should resume support for the Global Fund to fight AIDS, Tuberculosis and Malaria without delay.

41 The parliamentary motion found the support of the whole of Italian civil society, as well that of the Italian Institute of Public Health (Istituto Superiore di Sanità· ISS). See http://www.partitodemocratico.it/doc/260968/lotta-aids-mogherini-depositata-oggi-alla-camera-mozione-unitaria-per-rifinanziamento-fondo-globale.htm

42 The Netherlands does not include loans in its ODA, but a significant proportion of official ODA, 16% in 2012, is comprised of non-transfer items.

43 http://www.theglobalfund.org/en/partners/governments/

44 http://www.gavialliance.org/funding/donor-profiles/netherlands/

45 Dutch Advisory Council on International Affairs (AIV), 2013. Interaction between actors in international cooperation. Towards flexibility and trust. (February 2013) p.15.

46 Ibid.

47 Part of this decrease may be attributable to the change in the way multilateral aid is disbursed in 2012.

48 The Fondo para la Promoción del Desarrollo (FONPRODE) is the instrument of Spanish cooperation that channels funds in the form of loans to promote the private sector in developing countries and in the form of grants to multilateral agencies and bilateral aid.

49 International Development Priorities, The Conservative Party, last accessed: 31/07/2013 http://www.conservatives.com/Policy/Where_we_stand/International_Development.aspx

50 The Chancellor's statement on 20 March: "We also deliver in this coming year on this nation's long-standing commitment to the world's poorest to spend 0.7% of our national income on international development." https://www.gov.uk/government/speeches/budget-2013-chancellors-statement

51 BBC News, 26 September 2012. David Cameron reaffirms UK aid pledge at United Nations. Last accessed 3 June 2013 from http://www.bbc.co.uk/news/uk-politics-19709321

52 The Chancellor's autumn statement 2012. https://www.gov.uk/government/speeches/autumn-statement-2012-chancellors-statement

53 Thomas Reuters Foundation, 20 March 2013. Last accessed 3 June 2013 from http://www.trust.org/item/?map=uk-to-become-first-g8-nation-to-meet-07-pct-aid-pledge/

54 Equity investment comprises direct financing of enterprises in a developing country which does not (unlike direct investment) imply a lasting interest in the enterprise. See http://stats.oecd.org/Index.aspx?datasetcode=CRS1

55 http://www.kpmg.com/UK/en/services/Tax/CorporateTax/Pages/european-financial-transaction-tax.aspx#1

56 Guardian, 10 June 2013, http://www.guardian.co.uk/business/economics-blog/2013/jun/10/reports-death-financial-transactions-tax-exaggerated

57 Multilateral Aid Review, last accessed: 31/07/2013. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67583/multilateral_aid_review.pdf

58 Spending Round 2013, p.45, https://www.gov.uk/government/publications/spending-round-2013-documents , last accessed 20/09/2013

Acronyms

ACP	Africa, Caribbean and Pacific Group of States
AfGH	Action for Global Health
BMGF	Bill and Melinda Gates Foundation
BMZ	Federal Ministry for Economic Development and Cooperation (Germany)
CRS	Creditor Reporting System
DAC	Development Assistance Committee
DCI	Development Cooperation Instrument
DEF	Documento di Economia e Finanzia (Italy)
DFID	Department for International Development (UK)
EC	European Commission
EDF	European Development Fund
EIB	European Investment Bank
EU	European Union
FCO	Foreign and Commonwealth Office (UK)
FONPRODE	Fund for the Promotion of Development
FTT	Financial Transaction Tax
GAVI	The GAVI Alliance
GBS	General Budget Support
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GNI	Gross National Income
GPG	Global Public Good
IDA	International Development Association
IFFIm	International Financing Facility for Immunisation
KANCO	Kenya HIV/AIDS NGO Consortium
LIC	Low-Income Country
MDG	Millennium Development Goal
MIC	Middle-Income Country
MFF	Multi-annual Financial Framework
MMI	Medical Mission Institute Würzburg
MOD	Ministry of Defence (UK)
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development
PD	Democratic Party (Italy)
PvdA	Social Democratic Party (Netherlands)
SDG	Sustainable Development Goal
SGCID	General Secretariat for International Cooperation for Development
TB	Tuberculosis
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UK	United Kingdom
VVD	People's Party for Freedom and Democracy (Netherlands)
WB	World Bank
WFP	World Food Programme
WHO	World Health Organisation

Action for Global Health (AfGH) is a broad European network of Non-Governmental Organisations (NGOs) advocating in Brussels, France, Germany, the Netherlands, Italy, Spain and the UK towards the right to health for all and the health Millennium Development Goals (MDGs).

The goal of AfGH is increased support for European decision-makers of full funding of health, strong health systems and fair access to healthcare, accountable and responsive to the needs of vulnerable and poor people.

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