



## **DEVELOPMENT ASSISTANCE FOR HEALTH (DAH)**

*Average Commitments 1997-1999*

**Catherine Michaud, MD, PhD**

**August 2001**

## Health, Nutrition and Population (HNP) Discussion Paper

This series is produced by the Health, Nutrition, and Population Family (HNP) of the World Bank's Human Development Network ([HNP Discussion Paper](#)). The papers in this series aim to provide a vehicle for publishing preliminary and unpolished results on HNP topics to encourage discussion and debate. The findings, interpretations, and conclusions expressed in this paper are entirely those of the author(s) and should not be attributed in any manner to the World Bank, to its affiliated organizations or to members of its Board of Executive Directors or the countries they represent. Citation and the use of material presented in this series should take into account this provisional character. For free copies of papers in this series please contact the individual authors whose name appears on the paper.

Enquiries about the series and submissions should be made directly to the Editor in Chief. Submissions should have been previously reviewed and cleared by the sponsoring department which will bear the cost of publication. No additional reviews will be undertaken after submission. The sponsoring department and authors bear full responsibility for the quality of the technical contents and presentation of material in the series.

Since the material will be published as presented, authors should submit an electronic copy in a predefined format as well as three camera-ready hard copies (copied front to back exactly as the author would like the final publication to appear). Rough drafts that do not meet minimum presentational standards may be returned to authors for more work before being accepted.

The Editor in Chief of the series is [Alexander S. Preker](#) ([apreker@worldbank.org](mailto:apreker@worldbank.org)); For information regarding this and other World Bank publications, please contact the [HNP Advisory Services](#) ([healthpop@worldbank.org](mailto:healthpop@worldbank.org)) at: Tel (202) 473-2256; and Fax (202) 522-3234.

© 2001 The International Bank for Reconstruction and Development / The World Bank  
1818 H Street, NW  
Washington, DC 20433

All rights reserved.

# Health, Nutrition and Population (HNP) Discussion Paper

## Development Assistance for Health (DAH) Average Commitments 1997-1999

Catherine Michaud, MD, PhD<sup>a</sup>

<sup>a</sup> Research Associate, Harvard Center for Population and Development Studies, Harvard University, Cambridge, USA

Report prepared for Working Group 6 Commission on Macroeconomics and Health  
Version: August 2001

**Abstract:** This paper reviews the overall allocation of development assistance for health (DAH) and was designed to address four key current policy questions, namely the allocation of funds to (i) major causes of disease burden that overwhelmingly affect the poor; (ii) support country specific activities and the development and provision of public goods; (iii) technical assistance and administrative costs; and (iv) recipient countries. It provides an overview of resource flows to the health sector, and presents the allocation of funds as a function of income per capita, level of economic development, mortality strata, and country per capita spending on health. DAH commitments were estimated at 7.5 billion on average between 1997- 1999. The three lead agencies were the World Bank, the United States Agency for International Development (USAID) and the World Health Organization. DAH fared better than development assistance in other sectors during the past decade, and overall allocation of funds is targeting populations in greatest need. Countries with low income, high child and adult mortality, limited per capita public spending on health, received on average more DAH/capita than countries with higher income, better health outcome and larger public spending for health. The most important shortcoming of currently available data is the absence of standardization in agency reporting practices. This greatly limited our ability to address key policy questions in the rapidly changing context of globalization, and to conduct a detailed analysis of time trends in the allocation of DAH to specific components. The development of a standardized database that would include all major agencies is much needed. This will require a review of current coding practices and an agreement on a minimum set of internationally comparable data required to address key policy questions and monitor the overall efficiency of DAH in the future.

**Keywords:** health, development assistance, commitments, bilateral, multilateral

**Disclaimer:** The findings, interpretations and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

**Correspondence Details:** Catherine Michaud; 9 Bow Street; Tel: (617) 496 3867; Fax: (617) 495-5418; Email: cmichaud@hsph.harvard.edu Web: www.hsph.harvard.edu/hcpds/



## **Table of Contents**

<b>PREFACE.....</b>	<b>VII</b>
<b>ACKNOWLEDGEMENTS .....</b>	<b>VII</b>
<b>I. INTRODUCTION.....</b>	<b>1</b>
<b>II. DEFINITIONS AND DATA SOURCES .....</b>	<b>1</b>
<b>III. TRENDS AND GLOBAL OVERVIEW.....</b>	<b>3</b>
3.1 TRENDS AND GLOBAL OVERVIEW .....	3
3.2 DAH: AVERAGE YEARLY COMMITMENTS 1997-1999 .....	3
<b>IV. COMMITMENTS TO REGIONAL AND GLOBAL PUBLIC GOODS.....</b>	<b>12</b>
<b>V. BILATERAL AND MULTILATERAL COMMITMENTS TO SPECIFIC COMPONENTS</b>	<b>13</b>
<b>VI. SUMMARY AND MAIN RECOMMENDATIONS.....</b>	<b>13</b>
<b>ANNEX .....</b>	<b>15</b>



## **PREFACE**

## **ACKNOWLEDGEMENTS**



## I. INTRODUCTION

The review of resource flows to the health sector set forth to answer four basic questions:

- How much did major donors invest to reduce the burden of disease that overwhelmingly burden the poor: HIV/AIDS and other sexually transmitted diseases, malaria, tuberculosis, vaccine-preventable childhood diseases, and maternal and perinatal conditions ?
- Are resources directed to countries and populations in greatest need?
- How much did donors invest towards the development of global public goods, whose benefits extend well beyond National borders?
- What share of development assistance is spent to support technical assistance and administrative costs to the donor agency?

We found that the data currently available allows only for partial answers to these very basic and apparently simple questions. Multiple private and public sources contribute human and financial resources with the objective of improving health in developing countries. Unfortunately no single database yet exists that provides a comprehensive view of DAH beyond the most aggregate level, and no mechanism is in place to integrate data from all major donor agencies and monitor trends in the overall allocation of DAH. Little progress has been made in this area during the past decade, and calls for a much stronger focus in the future to enable donors to demonstrate and improve the effectiveness of DAH.

## II. DEFINITIONS AND DATA SOURCES

### *DAH and ODA*

Official development assistance (ODA) is defined by the OECD/DAC as grants and loans to countries and territories on Part I of the DAC list of Aid Recipients (developing countries) which are undertaken i) by the official sector; ii) with promotion of economic development and welfare as the main objective;(iii) at concessional financial terms (if a loan has a grant element of at least 25 percent.

ODA to the health sector is the largest component of Development Assistance for Health (DAH). DAH is broader than ODA and encompasses private funds which directly contribute to the promotion of development and welfare in the health sector in developing countries. It includes non-concessional loans provided by the World Bank and regional development banks to developing countries (i.e. WB IBRD loans); private foundations, and NGOs (own funds).

Governments provide official development assistance (ODA) funds through two major channels:

- (i) as direct bilateral aid, where transactions occur directly with partners in developing countries (mostly developing country governments, but also local or international NGOs);
- (ii) via multilateral organizations. Multilateral organizations comprise a) the UN family (WHO, PAHO, UNICEF, UNFPA and UNDP being the most important players in the health sector); b) the development banks: the African Development Bank (AfDB), the Asian Development Bank (ADB), the Inter-American Development Bank (IADB), and the World Bank (WB); and c) the European Community (EC).

### *Commitments vs. Disbursements*

Commitments and disbursements differ by the time at which they occur. Commitments are funds that are initially set aside to cover costs for the project, which most often spans several years. Disbursements are funds actually expended over the course of one year (calendar or fiscal year). Total amounts initially committed for a given project may differ from amounts actually spent, because funds that were initially committed may be canceled, reduced or increased during the project lifetime.

Most agencies routinely report commitments made each year, and only a few report actual disbursements. This is the reason why we chose to base our analysis on commitments rather than disbursements. Commitments tend to fluctuate from one year to the next. To minimize the impact of yearly fluctuations, estimates reported in this study are yearly averages over a period of three years (97-99).

### *Global and regional public goods*

In this study global and regional public goods were defined as commodities, services and resources that benefit entire regions or even the entire world. Others have extended the concept of global public goods to encompass all DAH activities and thus include the country-specific component of DAH.

### *Data Sources*

With the questions raised by the Commission on Macroeconomics and Health (CMH) in mind, we designed a questionnaire specifically for the purpose of this study in an attempt to fill important information gaps (see Annex 1). The questionnaire was sent electronically to major donor agencies in the public sectors. All development banks (AfDB, ADB, IADB, and the WB), two UN agencies (WHO, UNICEF), and two bilateral agencies (DFID, USAID) provided the detailed disaggregate information needed to answer the key questions raised by the CMH. Together these agencies commanded 68% of total ODA. The detailed analysis of the allocation of funds to specific diseases and conditions, to global public goods, and to technical assistance and administrative costs is limited to these agencies. We believe that they provide a reasonably plausible snapshot of the current allocation of ODA funds in the health sector and have no reason to believe that data from other agencies would significantly alter our main findings.

Where data from primary sources was not available, we resorted to information provided by the OECD/DAC and the Creditor Reporting System (CRS). This information is made available on-line by the OECD in Paris. The OECD/DAC database is the most reliable source for overall estimates of total aggregate bilateral commitments to the health sector, which includes health and population. It does not provide data by sector for multilateral agencies. Reporting to the DAC is mandatory. The CRS database started in compiles project listings and amounts committed for each project provided by each member country. Reporting to the CRS is not provided on a voluntary base. As a result the completeness of the CRS database varies between donor agencies, as well as for any single agency from year to year. Overall the completeness of the CRS database has improved over the years and is now close to 80 percent. The categorization used in the CRS for the health sector was developed by the OECD and is revised periodically (Frascatti Manual). A revision of the classification for the health is currently under consideration at the OECD. Unfortunately, the classification currently in use does allow for the type of policy analysis on which the CMH has embarked. The CRS database was very helpful in that it provides the name of recipient countries of funds committed for each project.

We also consulted all other published and non-published sources we could find. These included mostly annual reports (SIDA) and agency-wide, often internal, review papers (Norway, EC); the report prepared by the OECD for the CMH; and the report International Grant Making 1997, prepared by the Foundation Center.

### **III. TRENDS AND GLOBAL OVERVIEW**

#### **3.1 TRENDS AND GLOBAL OVERVIEW**

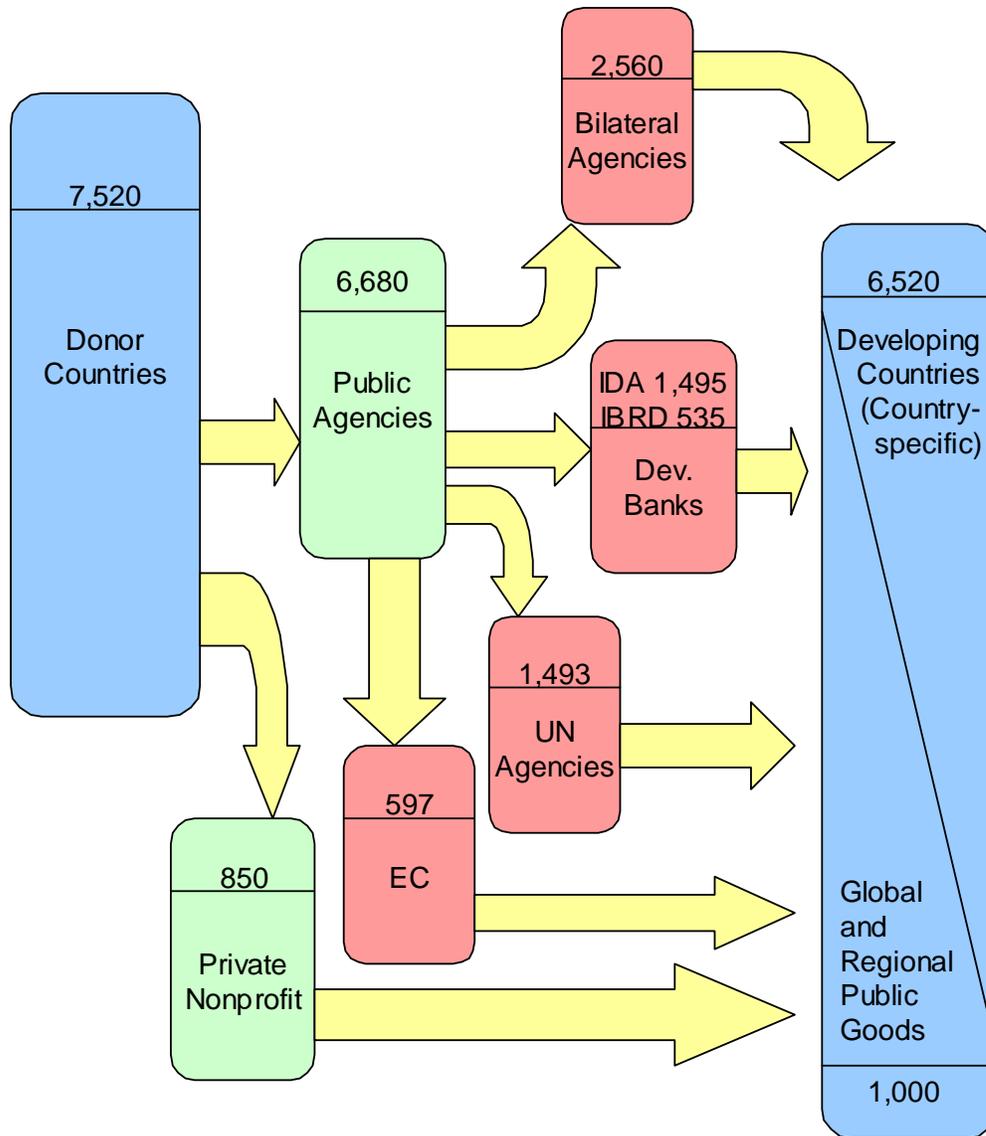
The share of total ODA allocated to health and population almost doubled during the 1990s, increasing from 6.7% in 1990 to 11.3 % in 1998. Total commitments increased from \$ 4.8 billion in 1990 to \$7.5 billion in 1998.

#### **3.2 DAH: AVERAGE YEARLY COMMITMENTS 1997-1999**

The public and private sectors in OECD countries committed an estimated 7.5 billion yearly on average between 1997 and 1999 to DAH. ODA is the largest share of DAH: public agencies committed almost 90 percent (\$6.7 billion) of total DAH. The remainder (an estimated \$ 850 million) came from the private-non-profit sector, which includes private foundations and NGO's own funds. The final recipients of the largest share of those funds are governments and NGOS in developing countries to support country-specific projects and programs (an estimated \$ 6.5 billion), the remainder (an estimated \$ 1 billion) was allocated to the development of regional or global public goods, defined as commodities, services and resources that benefit entire regions or even the entire world. (Figure 1).

The industry - mostly the pharmaceutical industry in the form of drug donations and in the process of drug development specifically geared to the needs of developing countries - also contributes to DAH but it is difficult to attribute a monetary value to these contributions. Major pharmaceutical companies were approached in the past to find out how much they invested in product development (drugs, vaccines, and diagnostics) for which beneficiaries would be primarily in developing countries. It declined to produce any estimates arguing that these would have to take into account the proportion of the overall infrastructure already in place for other product development, which would be very difficult to assess. This is the reason why the private-for-profit sector was not included in our estimates. Neither did we include R&D towards product development for which beneficiaries would be primarily in developing countries funded by the public funds in OECD countries because of the inherent difficulty in defining who the main beneficiaries of most R&D will ultimately be. All R&D worldwide is a global public good, and the WHO Ad Hoc Committee on Health Research Relating to Future Intervention Options underscored the need for increased funding to support to strengthen the human and institutional research capacity in developing countries (1996).

**Development Assistance for Health (D.A.H.)**  
**Average Yearly Commitments, 1997-99**  
*(millions of dollars)*



We would also like to draw the reader's attention to the fact that public and private sector agencies actively engaged in DAH do not function in isolation of each other. Increasingly over the past decade agencies have worked jointly and have formed a wide range of partnership schemes. We have kept agencies separate in this analysis for purpose of clarity. For instance, it would have been very difficult given the limited availability of integrated databases to quantify exactly the monetary value of "multi-bi" arrangements and other inter-agency monetary transactions, or of funds provided to NGOs. To minimize double-counting, funds provided by bilateral agencies to multilateral institutions were reported as multilateral funds. Estimates presented in this paper are based on all available data we could assemble and we believe that it nevertheless provides a fair representation of the overall size, distribution and recipients of funds committed to DAH.

#### *Bilateral and multilateral ODA*

Almost two third of all official development assistance funds provided to the health sector by governments (\$4.1 billion) are now channeled through multilateral agencies (table 1), and the balance (\$2.5 billion) is provided as direct bilateral assistance directly to developing countries (table 2). The World Bank, the United States Agency of International Development (USAID) and the World Health Organization (WHO) are the three lead agencies in the health sector, with annual average commitments ranging between US\$ 0.8 and 1.3 billion in 97-99. The European Community (EC) committed almost US\$ 600 million; the Japan Agency for International Development (JICA), the Department for International Development (DFID), UK, the Asian Development Bank (ADB) and the Inter-American Development Bank (IADB) each invested between US\$ 250 million and US\$ 360 million.

**Table 1: Multilateral investments by agency – yearly average 97-99**

US \$ (millions)

<b>UN system:</b>	<b>1,492.6</b>
WHO total (1)	864.2
<i>of which:</i>	
Regular budget	406.1
Extra-budgetary funds	458.1
UNICEF (2)	275.8
<i>of which:</i>	
Regular budget	
Other funds	
Other UN (2)	352.6
<b>Development Banks:</b>	<b>2,030.6</b>
World Bank total (3)	1,345.8
<i>of which:</i>	
IDA	722.0
IBRD	535.4
Inter-American Development Bank (IADB) (4)	245.7
Asian Development Bank (5)	287.7
African Development Bank (6)	151.4
<b>EC (7)</b>	<b>597.0</b>
<b>TOTAL MULTI-LATERAL</b>	<b>4,120.2</b>

(1) Source: Details of international health programme costs for 1998-1999 (actual disbursements)

(2) Includes PAHO own funds, UNAIDS, UNFPA, UNDP, IARC.

(3) Average commitments (IDA + IBRD) 1997-1999 – source: WB, Nandita Tannan

(4) Average commitments 1998-1999 - source: IADB database

(5) Average commitments 1997-1999 - source: ADB database (includes ADB, JSF, ADF and OCR)

(6) Average commitments 1997-1999 – source AfDB database

(7) Source: Overview of EC's Health, AIDS and Population Portfolio in Developing countries (1990-1999)

**Table 2: Bilateral investments by agency – yearly average 97-99**

US \$ (millions)

Country	Health	Population	Total
United States (1)	535.8	385.0	920.8
Japan	338.6	21.2	359.9
United kingdom (2)	267.0	19.3	286.3
Germany	118.6	65.7	184.3
France	128.4		128.4
Netherlands	80	21.5	101.4
Australia	64.8	14.9	79.6
Sweden	58.7	20.4	79.1
Spain	72.9	1.9	74.8
Belgium	58.8	1.7	60.5
Norway	41.3	15.1	56.4
Denmark	48.1	0.9	49.0
Austria	48.9	0.1	49.0
Canada	22.6	6.1	28.7
Italy	20.6	1.0	21.6
Switzerland	17.2	0.7	17.9
Finland	16.0	1.2	17.2
Luxembourg	16.2	0.5	16.7
Ireland	10.4		10.4
Portugal	8.6	0.1	8.7
Greece	5.8		5.8
New Zealand	3.1	0.2	3.3
<b>total bilateral (3)</b>	<b>1,982.4</b>	<b>577.5</b>	<b>2,559.8</b>

(1) Source: USAID database, covers all accounts

(2) Source DFID database

(3) All other bilaterals: from DAC on-line database

*Private Foundations and NGOs own funds*

The primary focus of our study was bilateral and multilateral ODA. It follows that we did not send the questionnaire to private foundations and NGOs, with the exception of the Bill and Melinda Gates Foundation. Estimates for other foundation were provided by a review of International Grantmaking in the US, compiled by the Foundation Center. This report estimated that US foundations contributed 16 percent of total US giving to developing countries (\$ 109 million) for health in 94. We assumed that US foundations contributed approximately the same amount to population (\$100 million), and that foreign foundations and NGOs own funds contributed another \$100-\$150 million. We think that it is plausible that the private non-profit sector contributed an estimated average yearly commitment of \$800 million - \$900 million between 97 and 99, of which \$458 million from the Gates Foundation. Commitments from long established foundations supporting international health have been relatively stable over the past 5 years. The Bill and Melinda Gates Foundation is new in the sector and now provides more than half of all private-non-profit commitments. Commitments increased from only \$2,9 million in 97 to \$1,2 billion in 99, and 685 million in 2000. It now ranks among the five leading institutions in DAH with average yearly disbursements of approximately \$ 600 million.

### III. REGIONAL AND COUNTRY-SPECIFIC ALLOCATION OF BILATERAL AND MULTILATERAL ODH.

Detailed allocation of bilateral and multilateral funds to specific countries was available for all bilateral agencies (OECD/CRS database); the development banks; WHO and UNICEF. These agencies jointly committed a yearly average (97-99) of \$5 billion to support country-specific activities, including \$535 million provided as IBRD loans. This represents 77 percent of the estimated total DAH committed on average for these years to country-specific activities (6.5 billion). The UNFPA, PAHO (own funds), UNDP, UNAIDS, the EC, private foundations and NGOs (own funds), for which commitments by country was not provided, were not included. (Appendix table1).

No clear pattern emerges from the per capita allocation of DAH to individual countries: it ranges from 10 cents or less to \$80 in Seychelles (population of only 77 thousand). Countries vary greatly in the value of summary statistics: population size, GDP per capita, overall health expenditures, and level of child and mortality, all of which might be significant determinants of the allocation of DAH. These country statistics vary within and between regions, and none of them follows regional boundaries. Furthermore, WHO and WB regional classifications of individual countries are not exactly the same. These factors led us to conclude that neither individual countries, nor regions provided the best unit of analysis to shed some light on the most important determinants of the allocation of DAH and ODA in the health sector.

To further our understanding of key determinants of the allocation of DAH and ODA, we clustered countries into different groupings:

- (1) by level of socio-economic development;
- (2) by current total health spending per capita;
- (3) by WHO mortality stratum.

#### *Allocation of DAH or ODA by level of socio-economic development*

For operational and analytical purposes, the World Bank's main criterion for classifying economies is gross product (GNP) per capita. Every economy is classified as low income, middle income (subdivided into low and upper middle) or high income. Low and middle-income countries are referred to as developing economies. For the purpose of this study low-income countries were further sub-divided into least developed and other low income. Least developed countries are defined Forty-nine countries are currently designated by the United Nations as "least developed countries" (LDCs). The list is reviewed every three years by the Economic and Social Council (ECOSOC).

The criteria underlying the current list of LDCs are:

- a. a low income, as measured by the gross domestic product (GDP) per capita;
- b. weak human resources, as measured by a composite index (Augmented Physical Quality of Life Index) based on indicators of life expectancy at birth, per capita calorie intake, combined primary and secondary school enrolment, and adult literacy;
- c. a low level of economic diversification, as measured by a composite index (Economic Diversification Index) based on the share of manufacturing in GDP, the share of the labour force in industry, annual per capita commercial energy consumption, and UNCTAD's merchandise export concentration index.

Different thresholds are used for inclusion in, and graduation from, the list. A country qualifies to be added to the list of LDCs if it meets inclusion thresholds on all three criteria. A country qualifies for graduation from the list if it meets graduation thresholds on two of the three criteria. For the low-income criterion, the threshold on which inclusion in the current list is based has been a GDP per capita of \$800, and the threshold for graduation has been a GDP per capita of \$900. In its July 2000 review, in the light

of recommendations by the Committee for Development Policy, ECOSOC declared the eligibility of Senegal for designation as an LDC (subject to the Government so desiring) and decided to postpone until 2001 its consideration of Maldives' graduation.

The criteria for determining the list of LDCs are under review. The Committee for Development Policy has recommended that the Economic Diversification Index be replaced by an Economic Vulnerability Index reflecting the main external shocks to which many low-income countries are subject, and incorporating the main structural elements of the countries' exposure to the shocks, including their smallness and lack of diversification.

**Table 3. DAH by level of socio-economic development – annual average commitments 97-99  
Bilateral Agencies, Development Banks, WHO, UNICEF**

Level of economic development	Population (millions)	DAH (millions)	DAH/capita
Least Developed	643	1,473	2.29
Other Low Income	1,777	1,666	0.94
Lower Middle Income	2,126	1,300	0.61
Upper Middle Income	564	610	1.08
High income	858	2	0.00
	5,969	5,052	0.85

Source: Data provided by AfDB, ADB, IADB, WB, WHO, UNICEF, DFID, USAID  
OECD CRS database for all other bilateral agencies

The striking finding in the distribution of DAH by level of socio-economic development is that DAH/capita to upper middle-income countries is higher than it is for other low- income countries and lower middle-income countries (table 3). This is due to non-concessional loans provided to upper middle-income countries by development banks. When only bilateral and multilateral ODA is included this anomaly disappears. ODA per capita to the health sector is inversely related to level of economic development. ODA per capita was \$2.29 in the least developed countries; 39 cents in other low-income countries; 32 cents in lower middle-income countries; and 15 cents in upper middle-income countries. Overall, the allocation of ODA per capita in the health sector is extremely low: less than one dollar per person in developing countries (table 4).

**Table 4. DAH: ODA and Non-ODA – annual average commitments 97-99  
Bilateral Agencies, Development Banks, WHO, UNICEF**

(US\$, millions)

	ODA/capita	ODA	Non-ODA (IBRD)
Least Developed Countries	2.29	1,473	0
Other Low Income Countries	0.39	695	48
Lower Middle Income Countries	0.32	1,181	119
Upper Middle Income Countries	0.15	223	386
High Income Countries	0.00	2	0
	0.75	4,498	553

Source: Data provided by AfDB, ADB, IADB, WB, WHO, UNICEF, DFID, USAID  
OECD CRS database for all other bilateral agencies

### *Allocation of ODA by levels of health spending per capita*

We also explored whether we could country levels of health spending per capita was a determinant factor in the allocation of ODA. Countries with low levels of health spending per capita are likely to be in greater need for development assistance than countries that already have high expenditures per capita. Countries were clustered into five different levels of health spending per capita: less than \$20; between \$21 and \$40; between \$41 and \$60; between \$61 and \$100; and \$101 or more. We found that even though 75 percent of total ODA went to in countries with the lowest health spending per capita, the allocation of ODA/capita in countries was lower where health spending per capita was less than \$41. Average health ODA per capita was less than \$1 in those countries, while it was \$2.2 in countries with health spending per capita between \$41 and \$60 (table 5).

One possible partial explanation to these findings is that per capita health spending might indicate that those countries have poorly developed health systems, and limited absorptive capacity.

**Table 5: Countries categorized by current per capita health spending:  
Annual average commitments 97-99  
Bilateral Agencies, Development Banks, WHO, UNICEF**

Countries categorized by current per capita health spending	Health spending per capita (unweighted average)	Total ODA for health (\$billion)	ODA per capita	Proportion of total ODA
\$0-\$20	12.6	2.12	0.91	46.7%
\$21-\$40	30.3	1.28	0.95	28.2%
\$41-\$60	51.5	0.45	2.22	9.9%
\$61-\$100	80.4	0.14	1.08	31%
\$101 and above	776.9	0.55	0.28	12.1%

Source: Data provided by AfDB, ADB, IADB, WB, WHO, UNICEF, DFID, USAID OECD CRS database for all other bilateral agencies

### *Allocation of health ODA by WHO mortality strata*

In the World Health Report 2000, the WHO classified countries into five different strata, according to levels of child and adult mortality: countries with (1) high child and very high adult mortality (only in Sub-Saharan countries); (2) high child and high adult mortality; (3) low child and high adult mortality (only in Eastern European countries);(4) low child and low adult mortality; and (5) very low child and very low adult mortality (mostly industrialized countries).

Levels of child and adult mortality are useful summary measures of overall population health in a country and a useful proxy indicator of health needs in a given population.

Countries with high child and high adult mortality are countries most affected by HIV/AIDS, all of which are in Sub-Saharan Africa. Average health ODA per capita to those countries was a little over \$2, almost twice as high as in countries with high child and high adult mortality (\$1.2 per capita). It was 57 cents per capita in countries with low child and low adult mortality. The surprising finding in this analysis is the very low investment in Eastern European countries with low child but high adult mortality (10 cents/capita). It is partly explained by the fact that bilateral and multilateral agencies have committed little funding to the prevention of premature death in young adults (Table 6).

**Table 6: ODA to countries categorized by WHO mortality strata  
Annual average commitments 97-99  
Bilateral Agencies, Development Banks, WHO, UNICEF**

Mortality stratum	population	Total ODA	ODA per capita
high child, very high adult	320,569	654,115	2.04
high child, high adult	1,935,257	2,347,613	1.21
low child, high adult	246,336	2,269	0.01
low child, low adult	2,588,794	1,483,545	0.57
very low child, very low adult	878,394	7,729	0.01

Source: Data provided by AfDB, ADB, IADB, WB, WHO, UNICEF, DFID, USAID  
OECD CRS database for all other bilateral agencies

#### *ODA to Sub-Saharan Africa*

Sub-Saharan Africa is without question the developing region in greatest need of assistance and warrants a closer look. To this end, we repeated the analysis of ODA by mortality strata, level of economic development, and level of health expenditures specifically for the region, and added the cluster of highly indebted countries.

Highly indebted countries in SSA was the cluster of countries with the highest yearly average commitments (\$3.47).

Average yearly commitments 97-99 for all country clusters were higher in SSA than it was for the same clusters when all developing countries were included. For example, average yearly commitments for countries with high child and high adult mortality in SSA was \$2.02 and \$1.21 for all countries in this strata; 2.47 for least developed countries in SSA and \$ 2.29 for all countries in this strata; \$1.93 for countries with health expenditures less than \$20 per capita in SSA, and \$0.91 for all countries in this category.

This data shows that, undoubtedly, donors committed more funds to SSA than they did for any other developing region. It is noteworthy that donors committed only 13.5 cents to China, which is a low middle-income country, with low child and adult mortality, and per capita health spending of \$20.

**Table 7: ODA to SSA - Selected country clusters**  
**Annual average commitments 97-99**  
**Bilateral Agencies, Development Banks, WHO, UNICEF**

Country cluster	Number of countries	population (thousands)	total	total Dev Banks (000s)	total WHO (000s)	total UNICEF (000s)	total bilaterals (000s)	total p.cap.
All countries in the region	47	623,679	1,282,029	224,210	77,486	82,423	897,912	2.06
High child, high adult mortality	28	303,110	612,914	124,230	45,062	49,355	394,268	2.02
High child, very high adult mortality	19	320,569	669,115	99,980	32,424	33,068	503,644	2.09
Heavily indebted countries	18	190,973	663,482	120,580	25,372	34,359	483,171	3.47
Least developed	33	375,299	927,222	189,330	58,235	60,944	618,712	2.47
Other low income	7	201,784	256,816	15,330	12,709	18,549	210,230	1.27
Lower middle income *	2	2,675	19,794	0	1,902	1,582	16,310	7.40
Upper middle income	5	43,921	78,197	19,550	4,640	1,348	52,660	1.78
Health exp. < \$20 p.capita	13	216,932	418,767	100,130	27,156	31,655	259,823	1.93
Health exp. \$21-\$40 p.capita	25	345,758	727,756	104,370	40,625	46,197	536,569	2.10
Health exp. \$41-\$60 p.capita	3	15,373	43,247	160	4,065	1,951	37,070	2.81
Health exp. \$101 and above	6	45,616	92,259	19,550	5,640	2,620	64,450	2.02

\* Namibia and Swaziland

#### **IV. COMMITMENTS TO REGIONAL AND GLOBAL PUBLIC GOODS**

One consequence of globalization in the health sector is the realization that major health threats such as the HIV/AIDS pandemic, the rapid increase in microbial resistance, the emergence or re-emergence of infectious diseases, harmful health effects of environmental changes and biological terrorism, are no longer confined to National borders.

The largest share of ODA has traditionally supported country-specific activities. There is a clear need in the new context of a global world to increase funding for regional and global public goods, defined as commodities, services and resources that benefit entire regions or even the entire world.

We estimated that only 1 billion (or 13.3 percent of total estimated DAH) was committed to support the development and provision of global public goods in the health sector. Multilateral agencies (WHO and the WB) committed a yearly average of \$ 460 million and the Gates Foundation \$461 million, and \$53 million, the balance being provided by other bilateral and UN agencies.

## **V. BILATERAL AND MULTILATERAL COMMITMENTS TO SPECIFIC COMPONENTS**

This analysis is limited to those agencies that completed the questionnaire developed for this survey, or provided sufficient information. These were WHO, UNICEF, Development Banks, DFID, and USAID. Country-specific activities were divided into 3 categories (disease specific projects and programs; systemic support to the health system; family planning and reproductive health), and a residual (other country-specific)

### *Disease –specific activities*

An estimated \$1.7 billion went to support disease-specific activities: \$337 million (20%) for HIV/AIDS, including STDs; \$250 million (15%) for vaccine-preventable childhood diseases; \$180 million (10%) for maternal and perinatal conditions; \$ 87 million (5%) for malaria; \$ 81 million (4.5%) for tuberculosis; and 47 million (3%) for non-communicable diseases. The balance of approximately \$ 660 million (40%) was reported as “other” disease-specific activities.

### *Systemic support to health systems*

An estimated \$875 million went to the systemic support of health systems, of which \$ 254 million (29%) were allocated to primary health care and \$148 million to secondary and tertiary care.

### *Family planning and reproductive health*

An estimated \$ 660 million (18%) was allocated to family planning and reproductive health programs. The balance of approximately \$ 250 million was not allocated to any specific country activity.

### *Technical assistance and administrative costs*

The allocation of funds to technical assistance and administrative costs provides another perspective on the allocation of funds. Approximately half of the funds for which we have data (approximately \$ 1billion) went to support technical assistance in the form of transfer of ideas and knowledge, and the other half to the transfer of equipment (drugs, vaccines, contraceptives, other supplies and local institutional capacity building).

Donor agencies estimates of own administrative costs ranged between 2 percent at the World Bank and 8 percent at WHO.

## **VI. SUMMARY AND MAIN RECOMMENDATIONS**

Average yearly commitments for DAH, an estimated \$ 7.2 billion between 97 and 99 has fared better than the overall ODA during the past decade but it still far from meeting real needs. Several factors have contributed to the increase in DAH during a time when total ODA dropped to its lowest historical levels. First the consensus among OECD/DAC members on major development assistance goals for the 21<sup>st</sup> Century clearly established the centrality of health, and underscored the need to reduce the burden of disease, particularly among the poorest populations, as a means to accelerate the pace of development. Second, several influential reports (WDR 93, Jamison et al. 93, WHO Ad Hoc Committee 96) and the first comprehensive assessment of the global burden of disease (Murray and Lopez 96) have provided the

objective evidence needed to inform difficult policy choices in the allocation of scarce resources, and made clear recommendations. Third, the devastating effects of the AIDS epidemic, the emergence of new infectious diseases, and the rapid spread of microbial resistance have become a major focus of global concern, extending well beyond the development assistance community.

First and most importantly, our analysis underscores how small investments really are – less than one dollar per capita. However, the analysis also highlights the fact the allocation of funds is moving in the right direction: a much larger share of all funds is provided to SSA (\$2.06 per capita vs. 75 cents per capita for all regions combined) and to countries in greatest need of assistance – the least developed countries (\$2.29 per capita), and countries which have the poorest health outcome as evidenced by high child and very high adult mortality (\$ 2.04 per capita), and high child and high adult mortality (\$1.21 dollar per capita).

No data was available regarding the allocation of funds to different components within countries.

Findings presented in the preceding sections illustrate the interest of the information that was available from selected agencies to inform health policy and to monitor changes in the allocation of resources over time. It also underscores the stark and frustrating limitations of the currently available data on resource flows to DAH to provide the objective evidence required to further improve the effectiveness of DAH.

There is an urgent need to revisit the classification currently recommended by the OECD, and to set up an institutional mechanism that would finally integrate, analyze, and regularly update data from all major donors in the public and private sectors.

## ANNEX

**Table 1.**

**AVERAGE YEARLY COMMITMENTS PER CAPITA, 1997-1999**

**SELECTED AGENCIES: BILATERAL AGENCIES, DEVELOPMENT BANKS, UNICEF, WHO**

Country Name	Total		
	population (thousands)	\$ (thousands)	total per capita
Afghanistan	21,923	15,270	0.70
Albania	3,133	20,707	6.61
Algeria	30,774	3,010	0.10
Andorra	75	0	0.00
Angola	12,479	33,218	2.66
Antigua and Barbados	67	35	0.52
Argentina	36,577	76,759	2.10
Armenia	3,525	9,213	2.61
Australia	18,705	24	0.00
Austria	8,177	0	0.00
Azerbaijan	7,697	182	0.02
Bahamas	301	275	0.91
Bahrain	606	246	0.41
Bangladesh	126,947	315,910	2.49
Barbados	269	205	0.76
Belarus	10,274	226	0.02
Belgium	10,152	0	0.00
Belize	235	558	2.38
Benin	5,937	26,573	4.48
Bhutan	2,064	15,029	7.28
Bolivia	8,142	93,993	11.54
Bosnia Herzegovina	3,839	9,997	2.60
Botswana	1,597	17,117	10.72
Brazil	167,988	166,153	0.99
Brunei Darussalam	322	38	0.12
Bulgaria	8,279	151	0.02
Burkina Faso	11,616	20,998	1.81
Burundi	6,565	9,985	1.52
Cambodia	10,945	49,798	4.55
Cameroon	14,693	18,185	1.24
Canada	30,857	265	0.01
Cape Verde	418	4,279	10.24
Central African Republic	3,550	1,072	0.30
Chad	7,458	21,150	2.84
Chile	15,019	16,518	1.10
China	1,273,640	172,420	0.14

Country Name	Total		
	population (thousands)	\$ (thousands)	total per capita
Colombia	41,564	10,704	0.26
Comoros	676	8,070	11.94
Congo, Dem.Rep.	50,335	6,428	0.13
Congo, Rep	2,864	2,300	0.80
Cook Islands	19	250	13.17
Costa Rica	3,933	15,333	3.90
Cote d'Ivoire	14,526	29,589	2.04
Croatia	4,477	675	0.15
Cuba	11,160	6,309	0.57
Cyprus	778	230	0.30
Czech Republic	10,262	21	0.00
Denmark	5,282	0	0.00
Djibouti	629	12,491	19.86
Dominica	71	577	8.13
Dominican Republic	8,364	69,584	8.32
Ecuador	12,411	23,611	1.90
Egypt, Arab Rep.	67,226	105,310	1.57
El Salvador	6,154	36,206	5.88
Equatorial Guinea	442	8,202	18.56
Eritrea	3,179	22,236	7.00
Estonia	1,412	40	0.03
Ethiopia	61,095	104,033	1.70
Fiji	806	17,033	21.13
Finland	5,165	0	0.00
France	58,886	0	0.00
Gabon	1,197	6,132	5.12
Gambia, The	1,268	12,026	9.48
Georgia	5,006	11,415	2.28
Germany	82,178	0	0.00
Ghana	19,678	57,475	2.92
Greece	10,626	0	0.00
Grenada	93	210	2.26
Guatemala	11,090	102,044	9.20
Guinea	7,360	22,600	3.07
Guinea-Bissau	1,187	8,507	7.17
Guyana	855	1,914	2.24
Haiti	8,087	50,760	6.28
Honduras	6,316	55,933	8.86
Hungary	10,076	29	0.00
Iceland	279	0	0.00
India	998,056	646,125	0.65
Indonesia	209,255	457,819	2.19
Iran, Islamic Rep.	66,196	1,814	0.03

Total			
Country Name	population (thousands)	\$ (thousands)	total per capita
Iraq	22,450	8,848	0.39
Ireland	3,750	0	0.00
Israel	6,101	19	0.00
Italy	57,343	0	0.00
Jamaica	2,560	10,858	4.24
Japan	126,505	39	0.00
Jordan	6,482	39,704	6.13
Kazakhstan	16,269	15,334	0.94
Kenya	29,549	57,200	1.94
Kiribati	82	414	5.05
Korea, Democratic Republic	23,702	3,199	0.14
Korea, Republic	46,480	706	0.02
Kuwait	1,897	330	0.17
Kyrgyz Republic	4,669	209	0.05
Lao People's Democratic Republic	5,297	1,722	0.33
Latvia	2,389	4,027	1.69
Lebanon	3,236	9,315	2.88
Lesotho	2,108	1,094	0.52
Liberia	2,930	11,338	3.87
Libya	5,471	741	0.14
Lithuania	3,682	39	0.01
Luxembourg	426	0	0.00
Macedonia, FYR	2,011	50	0.03
Madagascar	15,497	36,822	2.38
Malawi	10,640	90,528	8.51
Malaysia	21,830	846	0.04
Maldives	278	2,236	8.04
Mali	10,960	35,491	3.24
Malta	386	10	0.03
Marshall Islands	62	218	3.52
Mauritania	2,598	25,932	9.98
Mauritius	1,150	932	0.81
Mexico	97,365	247,780	2.55
Micronesia, Federal States of	116	331	2.85
Moldova	4,380	65	0.02
Monaco	33	0	0.00
Mongolia	2,621	14,860	5.67
Morocco	27,867	37,294	1.34
Mozambique	19,286	93,049	4.83
Myanmar	45,059	13,424	0.30

Country Name	Total		
	population (thousands)	\$ (thousands)	total per capita
Namibia	1,695	14,062	8.30
Nauru	11	36	3.27
Netherlands	15,735	0	0.00
Nepal	28,385	41,270	1.45
New Zealand	3,828	24	0.01
Nicaragua	4,938	80,872	16.38
Niger	10,400	28,291	2.72
Nigeria	108,945	56,852	0.52
Niue	2	68	33.87
Norway	4,442	0	0.00
Oman	2,460	868	0.35
Pakistan	152,331	63,487	0.42
Palau	19	1,384	72.83
Panama	2,812	5,075	1.81
Papua New Guinea	4,702	41,175	8.76
Paraguay	5,358	40,991	7.65
Peru	25,230	116,976	4.64
Philippines	74,454	99,899	1.34
Poland	38,740	22	0.00
Portugal	9,873	0	0.00
Qatar	589	123	0.21
Romania	22,402	178	0.01
Russian Federation	147,196	22,576	0.15
Rwanda	7,235	32,767	4.53
Samoa	177	1,004	5.67
San Marino	26	0	0.00
Sao Tome and Principe	144	801	5.56
Saudi Arabia	20,899	1,018	0.05
Senegal	9,240	72,814	7.88
Seychelles	77	6,156	79.94
Sierra Leone	4,717	7,212	1.53
Singapore	3,522	233	0.07
Slovak Republic	5,382	22	0.00
Slovak Republic	1,989	22	0.01
Solomon Islands	430	1,863	4.33
Somalia	9,672	11,041	1.14
South Africa	39,900	47,860	1.20
Spain	36,634	0	0.00
Sri Lanka	18,639	29,631	1.59
St Kitts and Nevis	39	20	0.50
St Lucia	152	53	0.35
St Vincent and the Grenadines	113	47	0.41

	Total		
Country Name	population (thousands)	\$ (thousands)	total per capita
Sudan	28,883	26,573	0.92
Suriname	415	1,029	2.48
Swaziland	980	5,732	5.85
Sweden	8,892	0	0.00
Switzerland	7,344	0	0.00
Syrian Arab Republic	15,725	2,225	0.14
Tajikistan	6,104	10,730	1.76
Tanzania	32,793	9,447	0.29
Thailand	60,856	23,838	0.39
Togo	4,512	5,994	1.33
Tonga	98	1,926	19.66
Trinidad and Tobago	1,289	478	0.37
Tunisia	9,460	19,573	2.07
Turkey	65,546	15,742	0.24
Turkmenistan	4,384	6,264	1.43
Tuvalu	11	118	10.75
Uganda	21,143	89,401	4.23
Ukraine	50,658	133	0.00
United Arab Emirates	2,398	205	0.09
United Kingdom	58,744	0	0.00
United States of America	276,218	50	0.00
Uruguay	3,313	728	0.22
Uzbekistan	23,942	27,818	1.16
Vanuatu	186	5,243	28.19
Venezuela, RB	23,706	896	0.04
Vietnam	78,705	77,224	0.98
Yemen, Rep.	17,488	19,678	1.13
Yugoslavia, FR (Serbia/Montenegro)	10,637	1,070	0.10
Zambia	8,976	39,250	4.37
Zimbabwe	11,529	35,215	3.05