Germany’s Contributions for Global Health and HIV Response in the Context of the Realisation of the Millennium Development Goals

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Introduction

Since the adoption of the Millennium Declaration by the United Nations and the Millennium Development Goals derived from it, the International Community was able to make remarkable progress in the control of major epidemics and the improvement of health care. On a global level, this especially applies to all urgent health issues resulting in a large number of deaths at an early age. By 2014, almost eight million deaths could be prevented by extending the access to antiretroviral combination therapy. In most regions of the world, life expectancy has increased considerably, while the massive decline in survival chances that occurred in countries severely affected by the HIV epidemic was at least reversed.

On the other hand, this can only be regarded as partial success, which is incidentally also very unevenly distributed. Many deprived people and population groups are still living under conditions, which are inhumane and hazardous to their health. At the same time, they are particularly excluded from vital health services due to lack of financial resources and political will. Two decades ago, the probability of dying before the age of 40 in low-income countries was seven times higher than in wealthy countries, whereas nowadays the population living in the first income group still faces a risk of premature death that is six times above the level calculated for the latter group. But the margin for the uneven distribution of survival chances is even higher in individual cases. A child that was born in Mozambique in recent years has a 20 times higher risk of dying at a much too early age under the present circumstances than a baby that was born in Germany.  

This is one of the most dreadful forms of injustice when people lose their lives because they are exposed to serious health risks as a result of their social situation and they are denied access to effective treatment options. The large-scale spread of HIV and the resulting dramatic mortality rate in

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the regions of sub-Saharan Africa, where a large part of the population has been forced to migrant labour for decades in order to survive, is one tragic example. In these regions the system of exploitation, which was established by colonial domination and was even exacerbated by Apartheid, was the reason for the separation of many families. Furthermore, gender relations were distorted to the extent that the economization and commercialization of sexuality was almost an inevitable consequence. During the era of the HIV epidemic the resulting behaviour led to a high risk of infection, while the political interest in awareness campaigns and health care for the migrant workers toiling in mines and plantations as well as their communities of origin tended to zero. The current patterns of HIV transmission still show that risk is closely related to social disadvantage and marginalization. Of the 2 million new HIV infections that are estimated to have occurred worldwide in 2014, roughly two thirds were recorded in sub-Saharan Africa and almost one out of six affected men who have sex with men.²

Socio-economic Inequality and the Need for Redistribution of Resources

Apart from overcoming structural health risks as well as the investigation of the most serious health problems of mankind, the improvement of survival chances largely depends on raising the required financial and personnel resources. Under the present economic circumstances, many countries are unable to mobilize the financial resources required for the provision of essential health care services from tax revenue and other domestic sources. An analysis of relevant parameters and projections indicates that about 40 countries, even when significantly increasing their individual efforts, will not be in a position to at least cover the minimum financing needs for health by the end of the decade without external support. If the global community intends to take the health-related targets of the 2030 Agenda for Sustainable Development seriously, international cooperation in this area has to be significantly increased and it also has to be put on a more reliable basis. Otherwise, the implementation will fail particularly in those locations and populations that are affected by the most severe deficits in human development. And the noble principle of leaving no one behind could be a hollow phrase right from the beginning.

Regarding health care and other critical areas for people’s life chances, the international cooperation should not only strive to ensure the absolute minimum, but also to reduce the huge gaps between and within countries. The overarching goal should be to orient scientific and technical progress towards the basic needs of the underprivileged majority of the world’s population, and, at the same time, enabling them to fully participate in the results of this progress.

Contrary to some statements, which only refer to most recent trends, the international income disparities and thus the necessity of resource transfers within the latest generation has not declined. The per capita income of 63 developing countries out of a total of 95 countries with available data, i.e. about two thirds, has decreased between 1980 and 2014 in relation to the average income level of the
economically better-off countries. The fact that China and India, the most populous countries, achieved a higher economic growth in this period than the average of advanced economies makes the picture more complicated with regard to global inequality on the population level. At the same time, both countries underwent a pronounced concentration of income in favour of the richest ten percent of their population, whereas the majority of people hardly benefited from the economic development. Instead, they endure the destructive consequences linked to the ruthless model of industrialisation and enrichment. Of the remaining development regions, 1.9 billion people are living in countries that have economically fallen even further behind in recent decades compared to the industrialized countries. Presently 55 percent of all developing countries have per capita income levels that do not even reach one tenth of the average seen in economically privileged nations.3

Due to the generally lower revenues in relation to the Gross Domestic Product and smaller health shares of public expenditure, the backlog of public spending for health care is often even more pronounced for the majority of developing countries than with regard to the national incomes. When taking into account the overall resources including the contributions through development cooperation, government spending for health per capita in 69 percent of the disadvantaged countries was lower than one tenth of the average level of the rich nations. This percentage rises to 82 percent, when calculating solely the amount of resources that was raised from national financing sources. In 47 countries, domestic funds allocated by governments to provide health services amounted to less than 2 percent of the average spending level in industrialised countries. Apart from the particular importance of health for wellbeing and development opportunities, often even the survival of people, the economic reality also points to the central role of health promotion for international cooperation.

International Obligations on Development and Health Financing

Unfortunately, the new development period already begins with severe political restrictions. The reason is that the new development agenda avoids a concrete and timely obligation with respect to the mobilisation of urgently needed financial resources. This applies to the promotion of official development cooperation by the economically privileged nations as well as to the respective efforts by the disadvantaged countries themselves. Government representatives took over this deficit from the outcome document adopted some months before at the Third International Conference on Financing for Development. Sad to say that the target for health financing does not go beyond non-binding statements, even though this sector is especially decisive for the realisation of the overall objective to ensure that all human beings can fulfil their potential in dignity and equality and in a healthy environment (Preamble).

It is imperative to overcome this attitude of many governments, which obviously refuse any firm commitments in order to favour the short-sighted interests of their own well-off clientele at the expense of the well-being of the vast majority of the world population. The definition of binding and appropriate financing targets for developmental efforts in general and health promotion in particular, is an indispensable prerequisite for the consistent implementation of the agenda. It also lays the basis for planning and implementation of the long-term support measures required for the strengthening of health systems, the training of professionals and the expansion of infrastructure.

Already back in 1970, the economically more advanced countries have pledged in a Resolution adopted by the United Nations to increase their Official Development Assistance (ODA) to at least 0.7 percent of their Gross National Income. Since this target was only reached by a few industrialised countries, the European Union decided on a step-by-step plan in May 2005 in order to implement the UN Resolution not later than 2015. Instead of consistently implementing this pledge, the majority of member countries had agreed upon yet another postponement prior to the Financing for Development Conference. Specifically, the European Union is planning to fulfil the UN target within the respective implementation period of the new development agenda, i.e. by 2030. During the crucial meeting of the EU Council for Foreign Affairs, Germany and France, in particular, are said to have prevented a renewed commitment to at least meet the financing target by 2020. This type of delaying tactic endangers the realisation of the sustainable development goals and undermines Europe’s credibility as a key player of global cooperation regarding development and humanitarian issues. It is necessary and urgent to revise this position and to replace it with a binding time-plan in order to fulfil the commitment not later than 2020, i.e. half a century after the pledge had been made.

The Commission for Macroeconomics and Health, which had been appointed by the World Health Organization, as a result of detailed research in 2001 came to the conclusion that the better-off part of the world ought to allocate at least 0.1 percent of its gross income for the development of health services in poor countries. Some years later, this recommendation was confirmed by further studies of the United Nations Millennium Project. The project investigated and described the investments required in the different development sectors in order to reach the Millennium Development Goals.
Methodology

There are indeed many reasons to take a closer look at the issue of financing as a key factor of political economy of health. For this reason, for several years now, a close partnership has been established between Action against AIDS Germany and the Medical Mission Institute Würzburg. The objective of this collaboration is the comprehensive and realistic assessment as well as the quantification of Europe’s contribution to Official Development Assistance overall and to the areas of health and HIV response, in particular.

For this purpose, the Medical Mission Institute has developed a methodology allowing a more precise estimate of the financial efforts for overall health promotion as well as for health-related Millennium Development Goals, such as HIV response and child health. The main focus lies on the review and the classification of all health-related aid activities according to analytical categories. This process comprises not only the projects and components, which have been reported as support to health, but also the activities identified because the respective description contains a health-related term. This applies to direct or bilateral cooperation between donor and developing countries as well as for the activities of health-relevant international organisations. The categorization uses a comprehensive definition of health that includes the basic elements of a health system as well as measures of prevention and the mitigation of social consequences of disease undertaken by other stakeholders outside the health system.

The database that documents the key data and descriptive information for all aid activities funded by official agencies of the member countries of DAC/OECD (Development Assistance Committee) constitutes the primary source of information. Furthermore, additional information is used, such as the reports to the Aid Transparency Initiative, project documents or other descriptions provided by the respective donor countries. This process is applied to correct those distortions that have occurred due to simple reporting errors and varying classification criteria. The primary goal is to provide a more accurate estimate that allows to compare the resource flows of different donor countries over the years as well as to relate them with the relevant needs analyses.

So far, the assessment covers the 17 European countries that had joined DAC/OECD before 2013. The study period begins in 2007, as complete data and meaningful project records were not made available for prior years. Last year, the study closed with the assessment of all aid activities implemented till 2013. This year, projects that have been implemented in 2014 are the main focus of the analysis. We are presently disposing of the assessment results of all health-related projects that took place in the course of Germany’s bilateral cooperation or those that have been funded by the most significant multilateral organisations such as EU institutions, the World Bank, the Global Fund and various UN Organisations. Overall, the research completed to date reviewed almost 105,000 project records containing individual project descriptions. In addition, the classification process included about 95,000 project components funded by the International Development Association (IDA) of the World Bank as well as over 127,000 activities reported by UN Organisations with typological descriptions.

While the study is the core piece, the scope of analysis was extended both geographically and regarding its temporal perspective for this report in order to produce a reliable estimate of the overall ODA disbursements for health in the form of grants during the entire MDG implementation period. For the years 2000 to 2006, the assessment had to resort to the data provided by donors on new
commitments specified by sectors, as the data for disbursements are incomplete. The analysis of bilateral cooperation on the part of the six non-European DAC countries from 2007 to 2013 is based on the officially reported aggregate data regarding the volumes and sectoral distribution of the ODA disbursements. In both instances, an adjustment was made using the empirical figures drawn from the study that indicate the respective percentages of resource flows reported in various sectors, which on average are supporting health promotion. On the one hand, this procedure results in lowering the amounts of ODA disbursements that were officially recorded as health activities. On the other hand it takes into account the respective proportions of ODA flows that were reported under other relevant sectors, such as education, governance and civil society, social infrastructure, humanitarian assistance or multi-sectoral approaches. For almost half of the donor countries including Germany, this tends to result in a higher estimate, whereas the adjustment has a reducing effect for all other DAC countries. This is an approximation to reality based on the evidence of the project-based assessment. It has been proven that a substantial amount of projects, which had been reported as directly supporting health promotion and certain sub-sectors, in fact do not coincide with the range of interventions as defined in relevant needs assessments. On the other hand, there is also a range of activities recorded in other sectors, which, at least partially, are to be classified as health measures.

In the case of Germany, the estimate of bilateral ODA disbursements for health in 2014 is already based on the review of the individual projects. For all other DAC countries, a preliminary calculation was prepared on the basis of official figures on the sectoral distribution of ODA disbursements applying the adjustment process described above. The calculation of health disbursements in the framework of bilateral cooperation of all donors as well as the multilateral organisations in 2015 is based on the determination of the health share in the overall financial commitments over the past three years (2012 to 2014). For this purpose, it was possible to use the consolidated results of the project review in the case of Germany. As far as the disbursements for the fight against the Ebola epidemic are supposed to represent additional funding in support of health, they have been taken into account for these two years. For this purpose, the information provided by “ONE“ and the data for humanitarian aid in favour of the three most affected countries have been combined.

The report reflects the current state of the assessment using the best data available at the moment. The future assessment of ODA expenditures for health, the HIV response and other priority health problems will increase the precision of these estimates. Based on previous experience, the project-based review will result in figures, which tend to be higher than official numbers.

This analysis focuses on ODA contributions, which have been actually transferred in the form of grants to developing countries or to relevant international organisations active in development cooperation. Only these resource transfers can, in principle, be used in order to meet the vast financing needs of the particularly disadvantaged countries and population groups supporting the priority sectors, which are imperative for human development such as the health sector. They also represent a real financial effort, whereas loans and equity investments are repaid to the donor countries, frequently with considerable interest rates and profits and in many instances monies from the capital market are used for such investments, as in the case of Germany. Furthermore, the real transfers of ODA grants between donor countries are comparable, whereas the actual financial consequences of the loans, which are imputed as ODA, both on the part of the providing countries as well as on the part of the receiving countries, are hardly calculable.
Overview of the Financial Efforts for the Realisation of the MDGs

Before taking a closer look at the ODA contributions for the different dimensions of the analysis, the below graphs will display the overall constellation of the most important performance benchmarks.

The first overview shows the financial efforts throughout the entire implementation period of the MDGs. This indicates that Norway and Sweden are the only two countries that have consequently fulfilled and exceeded the UN target for the overall ODA contributions as well as the recommendation by the WHO Commission for the cooperation in the health sector. When looking at the entire MDG period, Denmark has also achieved the target for the overall ODA and, with a ratio of 0.086 percent in relation to GNI, the ODA grants for health remained just below the recommended level. The Netherlands also came close to reaching both target figures. The contributions for the improvement of the health situation in developing countries provided by Ireland and the United Kingdom are also quite remarkable. The United Kingdom is also the only G7-member state, which has at least demonstrated above-average efforts. Belgium and Finland reached almost 50 percent of the envisaged contribution level for both dimensions.

Regardless of the quite significant differences, all other 14 DAC member countries are far from fulfilling their respective obligation. With a ratio of 0.262 percent of GNI for total contributions, i.e. less than 40 per cent of the target level, Germany remained far below its economic potential. The financial effort in supporting health care with a GNI share of 0.026 percent, i.e. only one fourth of the recommended percentage, is even more inadequate. The reverse situation was seen in the case of the United States of America that have the largest economy by far. Regarding the overall contributions, the USA only achieved a ratio of hardly 0.16 percent representing less than one fourth of the UN benchmark, but ODA grants in support of health promotion amounted to 0.038 percent of the GNI. Japan, the donor country having the second-largest economic capacity, even lags far behind these truly unsatisfactory contribution levels only reaching GNI ratios of 0.154 and 0.017 percent, respectively. Since these three countries account for 58 percent of the overall economic capacity for this entire period, the inadequate fulfilment of the internationally agreed or recommended financing targets by the respective governments had a serious impact on the total volume of resources mobilized in order to achieve the MDGs in particularly deprived countries.

While the debt crisis in some of the remaining countries may be a partial explanation for the insufficient level of contribution, this cannot be accepted as an excuse for the majority of the other countries. Austria’s performance has been especially poor in this respect with a total ratio of barely 0.2 percent and contributions for health of merely 0.015 percent of the GNI.
The following graph shows the contributions provided in the year 2014. The calculations are based on final data on the overall ODA grants, whereas the estimates of the contributions for health, with the exception of Germany, were produced by combining the officially reported data with the empirical values resulting from previous research. Thus, the graph allows a comparison of verified and largely secured estimates in the case of Germany with calculated results for all other DAC countries, which, in the course of the project-based analysis, will have to expect minor (in case of 16 European donor countries) or more significant (in case of the non-European countries) adjustments.

The graph for the year 2015 reflects the calculation of the overall grants on the basis of preliminary OECD data and estimates of the ODA for health based on precisely these figures as well as the sectoral distribution of recent commitments. Regardless of the remaining margins of uncertainty, it allows to get a clear picture of the current situation.

First it should be noted that the two best performing donors have held this position also in the recent past. All other countries should take them as an example. On the positive side, it can be said that the United Kingdom has also reached this high contribution level in the health area in recent years. The UK comes close to fulfilling the UN target for overall contributions, even without counting questionable expenditure items and accounting entries. Thus, the first G7 member country has met the targets and, in doing so, has mobilized a considerable amount of additional funds for development cooperation.
In contrast, Germany’s financial efforts continue to be quite insufficient, even if the respective ratios were somewhat higher in recent years compared to the period as a whole. With 0.28 percent of GNI recorded for the overall ODA grants (in both years) that were really transferred to developing countries as well as 0.030 percent (2014) and 0.031 percent (2015) of GNI concerning the grants in...
support of health, the contributions lag far behind the required level, which would be appropriate for a responsible player in global development. Presently, Germany ranks 11th for overall ODA grants and only 15th regarding the level of support for health promotion. This is indeed a disturbing result, when taking into account that at least 4 of the 22 long-standing DAC member countries are struggling with the massive consequences of the debt crisis, whereas Germany’s national economy has recovered outstandingly fast.

Meanwhile, the USA has reached 50 percent of the health-related target ratio, but the country has lately fallen back due to the delayed payment of the contribution to the Global Fund. Regarding the overall contributions, the USA belongs to the worst performing donor countries reaching 18th place in 2015. Similarly, Japan demonstrates a very weak performance, allocating only a small proportion of its limited ODA grants for health promotion and ranking 18th in this respect, with a ratio that increased slightly to 0.019 percent of GNI.

Development cooperation is still suffering from the fact that precisely those countries, which have the highest economic potential and, hence, importance for development cooperation, are showing completely unsatisfactory levels of financial effort. There is also a considerable risk that the majority of the economically advanced countries, which fall well short regarding their real ODA contributions in relation to economic capacity, will virtually turn the non-fulfilment of the international agreements and recommendations pertaining to development and health financing into a factual norm. This would be a fatal convergence not only for the realization of the new development agenda, but also for the urgently required international cooperation in regard to all global challenges and crises posing a threat for the future of the human family.

**Overall Performance for Development Cooperation during the MDG Era**

Overall ODA grants, after adjusting for inflation and exchange rates, provided by all DAC member countries combined have considerably increased during the first decade and in 2010 they were almost 70 percent higher than at the turn of the millennium. The adoption of the Millennium Declaration and the proclamation of the envisaged Millennium Development Goals have certainly had a positive impact. The pressure that was exerted by the organised civil society as well as the public opinion in general has motivated governments in many countries to increase their financial contributions. However, it has to be taken into account during the assessment, that the initial level was extremely low compared to the huge demand for development financing since many developing countries have fallen back economically even further in the previous decades and the capabilities of their services of general interest suffered from the devastating consequences of so-called structural adjustment programmes. If all DAC countries had just met the UN target in 2015, the total volume of ODA grants would have reached more than 321 billion US$ at constant price and exchange levels of 2014. Instead, the amount of ODA grants that was actually raised merely represents 36 percent of this hypothetical figure.

Meanwhile, the setback that occurred in the wake of the debt crisis has been reversed. The absolute level of the total contributions in recent years was only slightly higher than in 2010 and it stagnated during the final year of the MDG period.
As the following graph shows, the financial efforts during the first decade have increased as well. The ODA grants that have been raised by all DAC countries taken together as well as the contributions made available by all European DAC members combined, reached its highest level relative to the respective GNI in the year 2009 so far. Following the beginning of the debt crisis, both ratios have diminished and they have only slightly recovered up to now. This is the result of the above-mentioned tendency of stagnation of the amounts in absolute terms, whereas the GNI values of most countries, except for Greece, Spain and Italy, meanwhile exceed pre-crisis levels by a considerable margin. In 2015, the GNI of the European DAC members was 10 percent higher than in 2009, an increase of close to 14 percent can be recorded for all DAC countries, and Germany even reached a real growth of more than 15 percent.

The contribution level of the European donor countries combined, amounting to 0.338 percent of the GNI, was significantly higher than the average recorded for all DAC countries taken together of 0.236 percent, when looking at the overall MDG period. This difference of about 0.1 percent applies to the entire period and can mainly be ascribed to the extremely below-average efforts by the two countries with the largest economies, namely USA and Japan.
The overview of the real grant transfers provided by the most important donors illustrates that the real renewed growth of the total volumes of ODA grants after 2010 was mainly due to the additional efforts made by the United Kingdom, with an increase of almost 4.6 billion US$. Sweden – also having benefited from an above-average economic growth – and Switzerland increased the amount of ODA grants by more than a billion US$ each.
In contrast, the growth of the German contribution by 518 million appears to be quite modest, especially when taking into account the significantly higher economic potential. Since the beginning of the debt crisis, 11 DAC countries have increased their genuine ODA contributions, while the remaining 12 DAC countries reduced their funding. The biggest cuts in absolute numbers over the last five-year period were recorded for Spain (2.8 billion US$), the USA (1.9 billion US$) and France (about 1 billion US$).

Apart from the special case of Korea that joined DAC more recently in 2010, the United Kingdom achieved the highest growth rates throughout the MDG period by tripling the total amount of grants. After all, Sweden and Ireland doubled their contributions for development cooperation. The same applies for the USA, however starting from an extremely low level. Germany’s ODA contributions rose by 60 percent, which is still below the average increase of the DAC countries overall (71 percent) and the European members (63 percent). Out of the 23 DAC member countries, Denmark, Greece, Portugal, the Netherlands and Spain have lowered their contributions since the adoption of the Millennium Declaration.

In the 16 years since the turn of the millennium, the cumulated volume of ODA grants totalled slightly over 1.5 trillion US$ expressed in constant prices and exchange rates of 2014. If all DAC countries had consistently realized the UN target, the total volume would be three times higher and would have added up to over 4.5 trillion US$. Due to the well below-average performance of Japan and the relatively high efforts by the United Kingdom, Germany ranks third regarding the absolute amounts of ODA grants. The volume of about 148 billion US$ raised in the MDG period represented 9.7 percent of the total financial resources.
The picture is quite different when the ODA contributions of the various countries are put in relation to the economic capacities and thus looking at the actual financial efforts during the MDG era. Only 4 out of the 23 DAC countries reached the UN-agreed ratio and one other country almost met this target. Due to the very low contribution levels of the countries particularly affected by the crisis and the two largest national economies, Germany can be found in midfield. Germany’s efforts are far below European average and little above the simple average value of all DAC countries.

The development of financial efforts since the year 2000 shows that most DAC countries did not undergo noticeable changes of their positions within the donor structure. However, there are some exceptions with positive and also negative tendencies. The United Kingdom has by far made the biggest progress by raising its grant ratio between 2005 and 2013 alone, from 0.304 to 0.681 percent of the GNI and has almost held this level ever since. Special emphasis should also be placed on Norway and Sweden that have continuously fulfilled the UN target since 2001 and 2005, respectively, and even exceeded the benchmark by far in most years.
The Netherlands exhibit a trend in the opposite direction to the extent that the GNI ratio fell well below the target level in recent years. Spain represents the most dramatic example here. This country had achieved the highest growth rates between 2005 and 2009. But then within a few years, the country dropped from a good midfield position to last place among the more important donor countries.

When looking specifically at Germany’s ODA contributions, we observe that only during the short period from 2006 to 2009 the annual increase of ODA grants was sufficiently high in order to significantly raise the GNI ratio, whereas in most years the trend at best kept up with the economic growth. It must be noted that the financial effort for development cooperation as a whole has been stagnating on a completely insufficient level for a considerable time period since then.
Instead of a genuine increase of financial efforts, the focus has obviously shifted to an artificial inflation of the official ODA ratio through an extraordinary expansion of loans and equity investments. Since the reimbursements spread over a number of years, the balance that is counted as ODA applying current OECD criteria can thus be increased, at least on the short term. This type of manoeuvre also benefits from the fact that the official calculation procedure is not taking into account the interest repayments received by donors. The additional funds are not paid out of the government budget but are raised on the capital market, thus making a mockery of the concept of “official” or public development assistance. Except for a small surplus in 2011, the balance of the budgetary resources used for ODA lending was clearly negative, i.e. the recipient countries concerned are practically counter-financing a corresponding portion of the extended grants. Moreover, Germany, with a weighted average of 2.34 percent, charges the highest interest rates of all relevant bilateral and multilateral providers of ODA loans. Meanwhile, there is no other donor country that profits more from this practice of counting questionable items as ODA, which are neither to the benefit of the neediest countries, nor do they represent an actual effort. In 2015 this cosmetic improvement of the ODA statistic increased to 0.1 percent of the GNI.
When looking at the genuine efforts for development financing, it is quite apparent that Germany lagged far behind the average performance of the other DAC countries and especially the European donor countries, and the gap has not become smaller over the years.
Virtually throughout the entire timeframe of the realisation of the MDGs, Germany’s ODA contributions amounted to about half of the average contribution level of the other European DAC members, especially when excluding those countries most severely affected by the debt crisis. If Germany would have reached this level, it would have added up to an overall contribution of more than 209 billion euros, whereas the actual contributions made throughout the MDG period amounted to less than 104 billion euros.

**Genuine ODA contributions for Global Health**

The real ODA grants for the health sector expressed in constant US$ have tripled in the course of the MDG period. This can certainly be regarded as a notable success for the international community and civil society played an essential role in this positive change. Therefore, it was possible to save the lives of millions of people, which is the primary objective of cooperation in support of health care. It also becomes apparent that the Global Fund has quickly turned into the most important multilateral financing instrument, whereby the decline of payments seen in 2015 can mainly be ascribed to the delayed disbursement of the US contribution. The stagnation of the contributions for health through core contributions to the relevant UN organisations did not only have a negative effect on the mobilisation of the required resources, but also on the conceptual formulation and global coordination of development cooperation in the health sector.
Furthermore, the increase of ODA grants has to be seen in the context of the decade-long underfinancing of health services in most developing countries and the dramatic spread of the HIV epidemic in many resource-poor regions of the world. At the turn of the millennium, the ODA grants of all DAC countries taken together corresponded merely to one-fifth of the magnitude that the Commission for Macroeconomics and Health has considered necessary to establish basic health services also in deprived countries and to confront the most devastating threats for global health. Regardless of the increase during the first decade of the MDG period, the overall financial efforts did not even reach half of the contribution ratio suggested by the Commission and it has stagnated at this insufficient level in recent years. We are still far from closing the huge financing gap that exists regarding international cooperation for health promotion.

The collective efforts by the European donor countries for global health were well above average, but they considerably lagged behind the recommended minimum level. According to the preliminary estimates, Europe’s overall ratio in 2015 reached close to two thirds of the health-specific financing target. This expected increase is mainly due to the foreseen additional efforts by the United Kingdom. In this context, the estimated resources provided to confront the Ebola crisis played quite a significant role, whereby it still remains uncertain to what extent these contributions are actually representing additional funds for the health sector or whether they have merely been shifted within the sector. On the basis of the available data and under favourable assumptions regarding the percentage of the funds made available for this purpose in addition to already committed health financing, the overall contributions for 2014 and 2015 can be estimated at close to 1.5 billion US$, of which Europe has provided 840 million or almost 57 percent. The current insufficient availability of data regarding the special need to deal with this disease outbreak as well as the overall contributions for health is creating a significant uncertainty.
Global health financing primarily depended on the G7 Countries as well as Australia, the Netherlands, Norway and Sweden. These 11 countries provided close to 90 percent of the overall ODA grants for health throughout the MDG era. For most donor countries, this is simply the result of their exceptional economic capacity. But Norway, Sweden and to a lesser extent even the Netherlands, have become important contributors because their financial efforts are considerably above average. In recent years, the United Kingdom has shown particularly impressive increases. After the USA, with the by far largest economy, the United Kingdom has established itself as the second most important donor country. The British grant volumes are meanwhile well above the annual financial resources paid by all other donor nations, despite the fact that some of them have a higher GNI.

Not only the United Kingdom, but also France is ahead of Germany regarding the amount of contributions for the realisation of the health-related MDGs. Germany’s genuine total contribution of 14.5 billion US$ corresponded to merely a share of less than 6 percent of the grant disbursements made by the DAC countries combined and thus it was considerably lower than the share of the GNI of 8.7 percent. The European DAC countries taken together contributed over half of the amount, while they account for roughly 41 percent of the total economic potential.
There is quite a large span when looking at the contributions for health in relation to the economic capacity. Only three DAC countries have exceeded the threshold value of 0.1 percent of the GNI. The United Kingdom is the only G7 member among the 9 DAC countries that have achieved at least half of the target value during this timeframe. Most countries, among them those with the largest economies, provided only a mere fraction of the recommended level of contribution. This leads to an enormous deficit and to an increased fragility of health financing.
Germany can be found at the end of the ranking list. When putting aside countries that were particularly affected by the debt crisis and the special case of Korea (that had joined the DAC more recently in 2010), only the ratios for Japan, New Zealand and Austria are even lower.

![Financial Effort in support of Health in Disadvantaged Countries over the MDG period 2000-2015: ODA Grants in relation to GNI](image)

A glance at the development of the financial efforts over the MDG period clearly reflects that only a few countries have attempted to meet the target value for contributions in support of health at an early stage. Norway exceeded the recommended ratio already in 2001 and Sweden followed in 2005. It is quite remarkable that both countries reached the minimum level on a continuous basis after that, and in most years their efforts went well beyond that threshold. The United Kingdom joined this leading group in recent years with an outstanding increase of the ODA contributions for health. The United Kingdom is also the only G7 member that has achieved the recommended contribution level, which it has considerably exceeded in the meantime, whereby all other member countries are far from reaching this goal. The small group of exemplary contributors is up against the majority of DAC countries where the ODA grants range hardly between one fifth and half of the target value, without a prospect of appreciable improvement.
When looking at Germany’s ODA grants for global health, a significant growth from 2006 to 2009 can be noted in parallel with the trend of overall contributions for genuine development aid. A large part of this increase was due to the considerably higher contribution to the Global Fund. However, the efforts in relation to the GNI never achieved even one third of the target value. Thus, the ODA grants...
for health are even considerably more inadequate, as was already observed when assessing the total aid flows, compared to the respective financing targets. Regarding the last five-year period, it has to be stated that the efforts were stagnating. The predicted increase of the contribution in 2015 is based on the favourable assumption that the financial resources for the control of the Ebola crisis and the consequently created special programme “Health for Africa” will be made available in addition to the existing financial commitments for health projects. In view of the limited increase of the total budget of the Ministry for Development Cooperation (BMZ) amounting to hardly 100 million euros or 1.5 percent compared with the previous year, this is questionable at least.

In relation to the average value of financial efforts for global health that have been made by other European DAC countries with comparable economic conditions, Germany’s insufficient level of contribution becomes apparent. In nearly every year of the MDG period, this comparative figure was three times higher than Germany’s GNI ratio. Even if the four countries hit especially by the crisis are included in the calculation, the European average was twice as high as the German contribution level. And even the average efforts by all DAC countries including the six non-European member countries in most years was twice the size of the contribution level recorded for Germany.

If Germany had achieved the average level of the economically comparable European DAC countries over the timeframe of the realisation of the MDGs, this would have amounted to an overall contribution of almost 31 million euros. In reality, Germany’s contribution for the realisation of health-related goals totalled little more than 10 billion euros, resulting in a shortfall of almost 21 billion euros. Thus, Germany does bear a special responsibility for the improvement of the living and health conditions in the economically deprived regions of the world, not only with regard to the fact that it represents the largest economy in Europe, but it has every reason to compensate for the cumulative
contribution shortfall during the MDG period by making increased efforts in the coming years for the realisation of the 2030 Agenda.

ODA Contributions for the Control of the HIV-Epidemic

In contrast to the trend observed for Europe’s ODA grants for the health sector as a whole, showing a renewed increase (especially caused by the higher contributions from the United Kingdom) in the year 2013, the genuine contributions for the global response to the HIV epidemic persistently decreased during the study period. However, during the past two years, this negative tendency could be partially reversed due to an increase of the amount of contributions to the Global Fund provided by European donor countries combined, mainly due to increased grants by the United Kingdom. The cancellation of payments to the Global Fund by Italy and Spain following the debt crisis had caused at least a significant portion of the overall decrease of contributions made available by Europe.

It is obvious nevertheless, that the significance of the response to the HIV-epidemic in the framework of bilateral cooperation has noticeably declined. This is based on a comprehensive estimate, which does not only include specific HIV interventions, but also HIV components in projects of reproductive health and sector-wide health programmes. In addition, there has been a declining tendency of the share of HIV interventions in relation to total disbursements in the case of important multilateral financing mechanisms, such as the European Union and IDA. Urgent countermeasures have to be taken in this respect in order to fulfil the respective target of the 2030 agenda, namely to end the AIDS epidemic.
Accordingly, Europe’s collective ratio in relation to the GNI after 2010 has diminished considerably. In addition to the cuts made by the above mentioned crisis-stricken countries, the grant volumes of France (especially due to falling contributions to UNITAID) and the Netherlands (first of all due to declining bilateral contributions) also dropped by more than 100 million US$ and thus below the level of 2007, after adjusting for price levels.
Similar to the overall health promotion, Germany only ranks third among European donors with respect to the absolute amount of the contribution provided during the period reviewed to date, although the country has the largest economy by far. In this time period, the contributions by the United Kingdom were twice as high as Germany’s grants and France also contributed about 50 percent more. The amount made available by Sweden, Norway, and the Netherlands taken together, was more than twice as high as the contribution provided by Germany for the global HIV response, even though the combined economic capacity of all three countries corresponded to hardly half of the German GNI.
Despite the position shifts of some countries, the differences in the financial efforts for the global response to the most devastating epidemic are quite similar than for the overall improvement of the health situation. Germany ranks far behind in the lowest places and reduces the European overall volume due to its low contribution level. Apart from the crisis-hit countries, only Switzerland and Austria were even less generous in the support of the HIV response in economically deprived countries.
A glance at the development of grants in relation to the economic capacity of individual countries shows, that in the course of the study period there has been a reduction especially in those countries with the highest performance. The United Kingdom is once again one positive exception in this case, even though the increase of the efforts for the global response to the HIV epidemic – mainly due to the varying contributions to the Global Fund over the years - did not show a linear tendency.

The volume of grants provided by Germany has been stagnating since 2008 when the last significant increase of the contribution to the Global Fund had taken place. The fluctuations of the total amount can mainly be attributed to the varying HIV proportion of the total disbursements made by EU institutions and IDA over the years. The bilateral grants remained at a quite constant level of 70 up to little over 80 million euros. The growth projected for 2015 is based on the favourable assumption that the funds for the special programme “Health for Africa” will be provided in addition to the commitments previously made for health projects. According to the analysis that had been carried out in the course of the 2015 ODA study and which is based on WHO data on national health accounts in combination with the scope of HIV interventions as documented in the project-level database of the DAC/OECD, about 15 percent of external financial resources for health sector programmes in sub-Saharan Africa is being used for HIV interventions.

The remainder of the European DAC countries, which are comparable in economic terms, on average made contributions that were three times as high as the German contribution for the global response to HIV. Even when including those countries that were considerably affected by the debt crisis, Germany still ranks far below Europe’s average financial efforts. The gradual narrowing of the gap between the ratios in the last years of the study period unfortunately could not be attributed to the increased effort by Germany, but to the declining contributions by other European donors.
Contributions to the Global Fund to fight AIDS, Tuberculosis and Malaria

The Global Fund is the most important financing instrument for the control of the most devastating infectious diseases and the improvement of the health situation in the particularly deprived countries overall. The grants by the Global Fund have created the possibility to plan and to implement prevention and treatment programmes that are at least approximately commensurate to the dimensions of the challenges. The Global Fund has set new standards regarding the involvement of self-help initiatives and civil society organisations which are indispensable for reaching key populations made vulnerable to HIV due to social conditions, the protection of human rights, and, ultimately, for the effectiveness of programmes. Furthermore, the programmes supported by the Global Fund, have substantially contributed to the strengthening of central elements of the health systems in recipient countries. A suitable and reliable participation in the financing of the Fund is a central task of the economically better-off countries in order to fulfil their obligation for global health.

Even when looking at the absolute overall amounts of the contributions, Germany ranks fourth of all donor countries behind France and the United Kingdom. In the period up to 2013, Germany was still in third place, but due to the insufficient increase during the current replenishment period, Germany fell far below the British contribution. In this overview the EU contribution has been attributed to the respective member countries according to their share in financing of the total of ODA resources administered by EU institutions (budget and European Development Fund).
For the whole period since the inception of the Fund till the foreseen contributions this year, an average contribution ratio in relation to the collective GNI of 0.0087 percent can be calculated for the economically comparable countries in Europe. With 0.0066 percent or in other words 66 cent per 10,000 Euro of the economic capacity, Germany’s contribution was considerably below this level. For the current replenishment period of 2014 to 2016 the gap is expected to decrease somewhat, but it still will remain significant. According to the economic outlook of the IMF and the pledged contributions, the European countries with similar economic characteristics, will raise on average 0.0095 percent of their joint GNI for the Fund, whereas Germany’s contribution level can be estimated at 0.0079 percent or 79 cent per 10,000 Euro of the GNI.

At the same time, however, the fund represents the most important financing channel for Germany’s aid in support of this critical area for human development, accounting for 43 percent of the total volume of ODA grants provided for the HIV response in the period from 2007 to 2015. Regarding the contributions for the health sector as a whole the Global Fund received one fourth of the overall volume, which represented the second highest share following bilateral cooperation.

When evaluating the financial efforts in favour of the Global Fund, Germany ranks tenth when considering the total timeframe. In the current replenishment period Germany’s contributions relative to GNI will presumably rank in eighth place.

In order to achieve the average contribution level of comparable European countries in the total period reviewed, Germany would have to raise an additional 825 million euros for the Fund. Just like all other financing deficits described in the above chapters, this shortfall should be taken into account, if we turn to the question which contributions Germany should be making in the future in order to fulfil its obligation for the promotion of global health.
Germany’s Imperative Way to a Fair Contribution for Health

The realisation of universal health coverage and the end of AIDS and other devastating infectious diseases represent cornerstones of the 2030 Agenda for Sustainable Development. The improvement of the still completely unsatisfactory health situation in many economically deprived countries is indispensable in order to meet the primary objective to enable people to lead a long, creative and self-determined life. Health is the yardstick for the social advancement and is closely interconnected with all other dimensions of human development. Thus, health promotion is of exceptional importance in global development cooperation and politics.

In order to provide life-saving health and HIV services also and especially in locations, where the structural vulnerability and economic hardship are the worst, the contribution level of most economically privileged countries including Germany has to be raised considerably. In connection with the enhanced own efforts by the developing countries, it will be possible to close the enormous financing gaps. Due to their involvement in colonial exploitation, which has caused immense suffering for the affected people and produced structural barriers for development and health, the European countries have a special responsibility. Furthermore, according to the current reality of development aid, Europe raises almost 60 percent of the total ODA grants. Thus it can be assumed that European contributions in the years to come will have to amount to at least 50 percent in order to have a realistic chance to mobilise the additionally needed financial resources as quickly as necessary.
The realisation of the UN agreed target ratio by 2020 has to be the basis. This means that this global financing target will finally be achieved half a century after the original obligation and a decade and a half since the renewed commitment by the European Union. Then it will be possible to overcome the prevailing bottlenecks that have provoked unbearable conflicts about objectives. This is the necessary prerequisite in order to move forward in all areas of human development, i.e. not only directly tackling the enormous health problems, but also making significant progress to overcome their structural causes and social consequences.

The elaborated estimate of the fair contribution for health promotion as well as the end of the AIDS epidemic as a public health threat is based on these criteria and brings together the current needs assessments with the latest economic forecasts. For this purpose, a projection of ODA grants for health in the current year has been compiled, which is based on the study results and assumptions already mentioned above as well as the respective titles in the federal budget of 2016.

In case of this scenario, Germany would achieve Europe’s required average contribution level by 2020. The impression that the planned rates of increase appear to be quite significant, is simple due to the fact that the starting level is so far below the European benchmark. If Germany would implement these increases, it would be able to achieve the contribution level which has already been reached on average by the leading European contributors. This is without taking into account the enormous deficits of Germany cumulated during the MDG period.
A central component is the increase of the contribution to the Global Fund to a suitable level. For the upcoming replenishment period for 2017 to 2019, a fair overall contribution in the amount of 1,428 million US$ has to be calculated, which would correspond to about 1,275 million euros. When deducting the co-financing of the already pledged EU contribution, a bilateral contribution of close to 1,200 million would have to be paid over the period of three years.

The suggested increase of ODA contributions for global health is to be regarded as an investment in the future. Thus, Germany would be providing the chance to take a great step forward for the global efforts in the improvement of the health and living conditions for the deprived majority of the world population. Thus, it would help to prevent immense human suffering and to create decisive prerequisites for sustainable development. Furthermore, with this important sign of human solidarity, Germany would gain a new kind of credibility, which is of crucial importance in the political dialogue to overcome international conflicts as well as the formation of a more just and future-oriented world order. One part of this new order should also include a global plan of action, with the goal to secure universal access to essential health services for all people without pushing them into poverty. This requires a funding model, which will overcome the uncertainty of voluntary contributions and which will instead be based on a fair system of obligatory contributions.