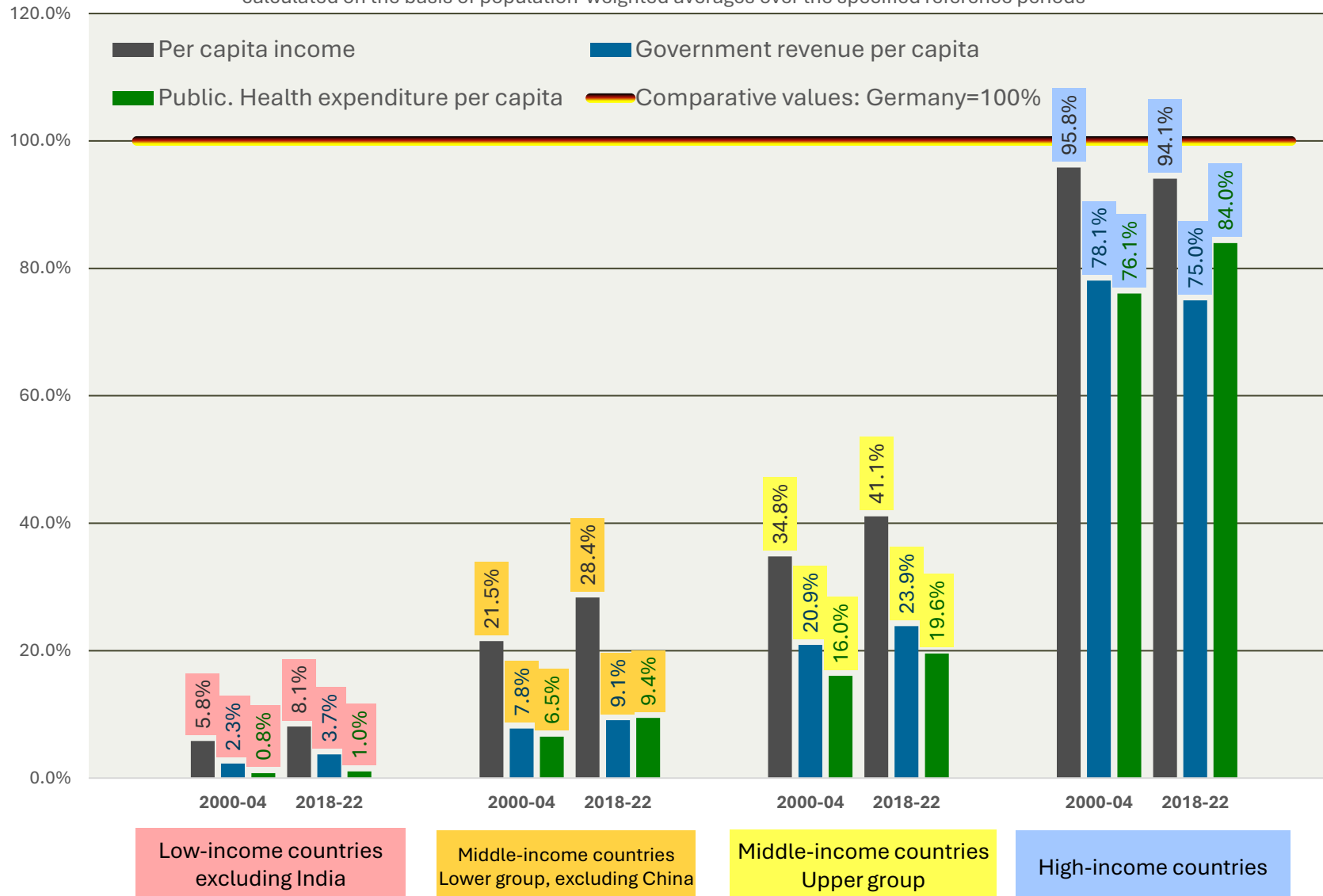


**Irreplaceable, effective, affordable, responsible:
Why ODA is crucial for global health**

June 2025

ODA is irreplaceable: low-income countries have too few domestic financial resources

Key figures for public financial resources in relation to Germany
calculated on the basis of population-weighted averages over the specified reference periods



In order to assess the importance of development cooperation for a fairer distribution of resources and life chances, countries that were classified as low-income countries by the World Bank before the year 2000 should be considered in particular. For 53 of these 58 countries, all essential data for the domestic and international mobilisation of public funds from 2000 to 2022 are available. Excluding India, the population of the remaining 52 nations rose from 1.1 billion to almost 1.8 billion during this period.

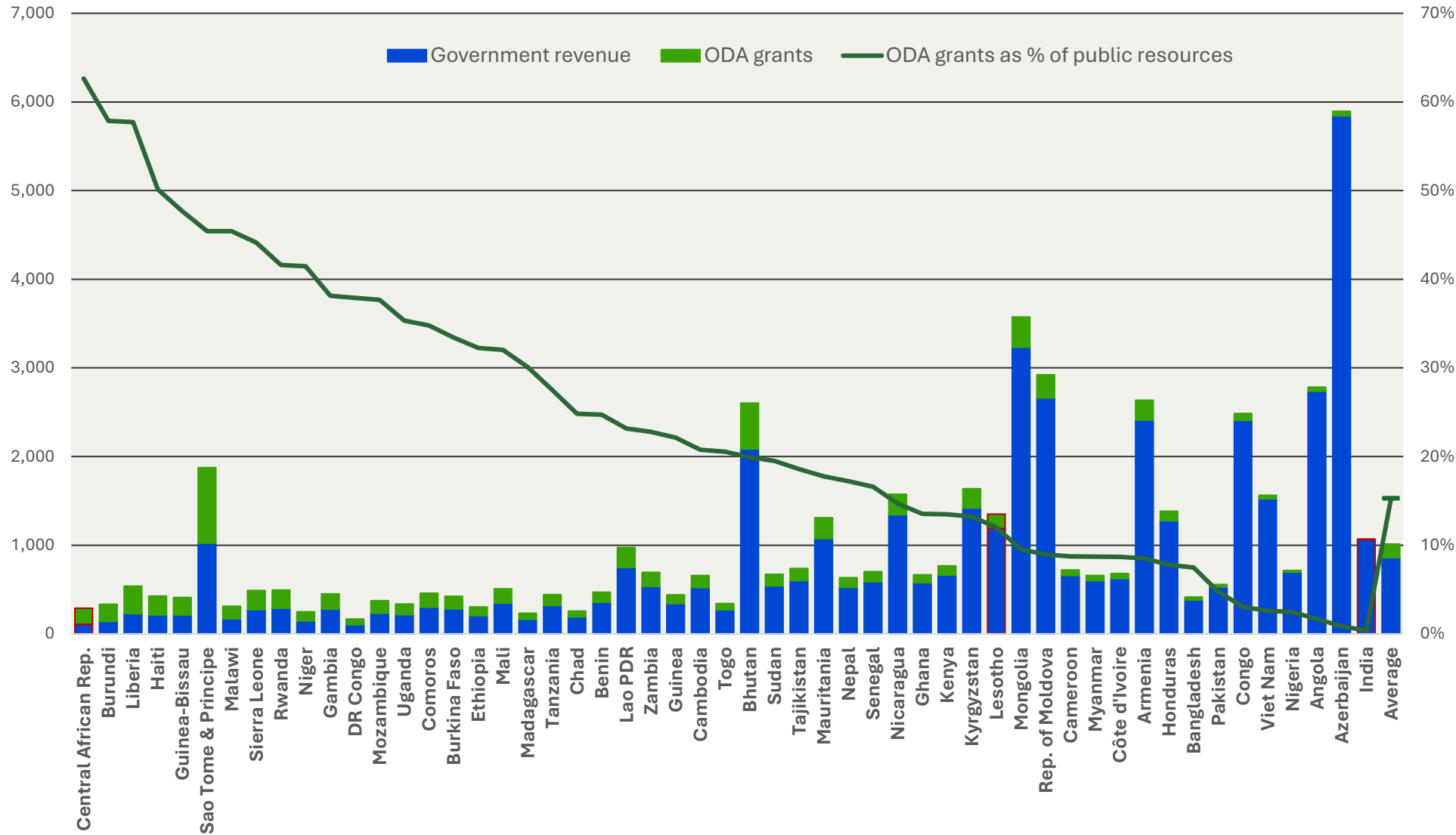
These poorest countries in the world continue to have very limited financial resources compared to Germany. Since the Millennium Development Goals, however, there have been significant catch-up effects: per capita expenditure on health doubled from 30 to over 60 int. US\$ there, while it rose by 65% in rich countries and by around 50% in Germany (from about 3,900 to almost 5,900).

There are large differences in per capita income, government revenue per person and public health expenditure per capita in a country comparison. Compared to Germany, the domestic financial resources of low-income nations have improved only marginally and are still completely inadequate for sufficient health care funding.

All calculations are based on constant international US\$ from 2021, which corresponds to the purchasing power of one US\$ in the US in the reference year and allows a purchasing power-adjusted comparison of prosperity between countries. However, this can overestimate the financial strength of poorer countries, as they face greater import dependence in the health sector than is the case with general consumption.

ODA is irreplaceable: many low-income countries are dependent on development cooperation

Low-income countries before 2000: Government revenues and ODA grants in the period 2000-2022,
Mean values in constant int. \$ of 2021



This graph presents a comparison between government revenues and official development cooperation (ODA) grants of low-income countries with available data. The curve represents the percentage of ODA grants in all public resources of the countries.

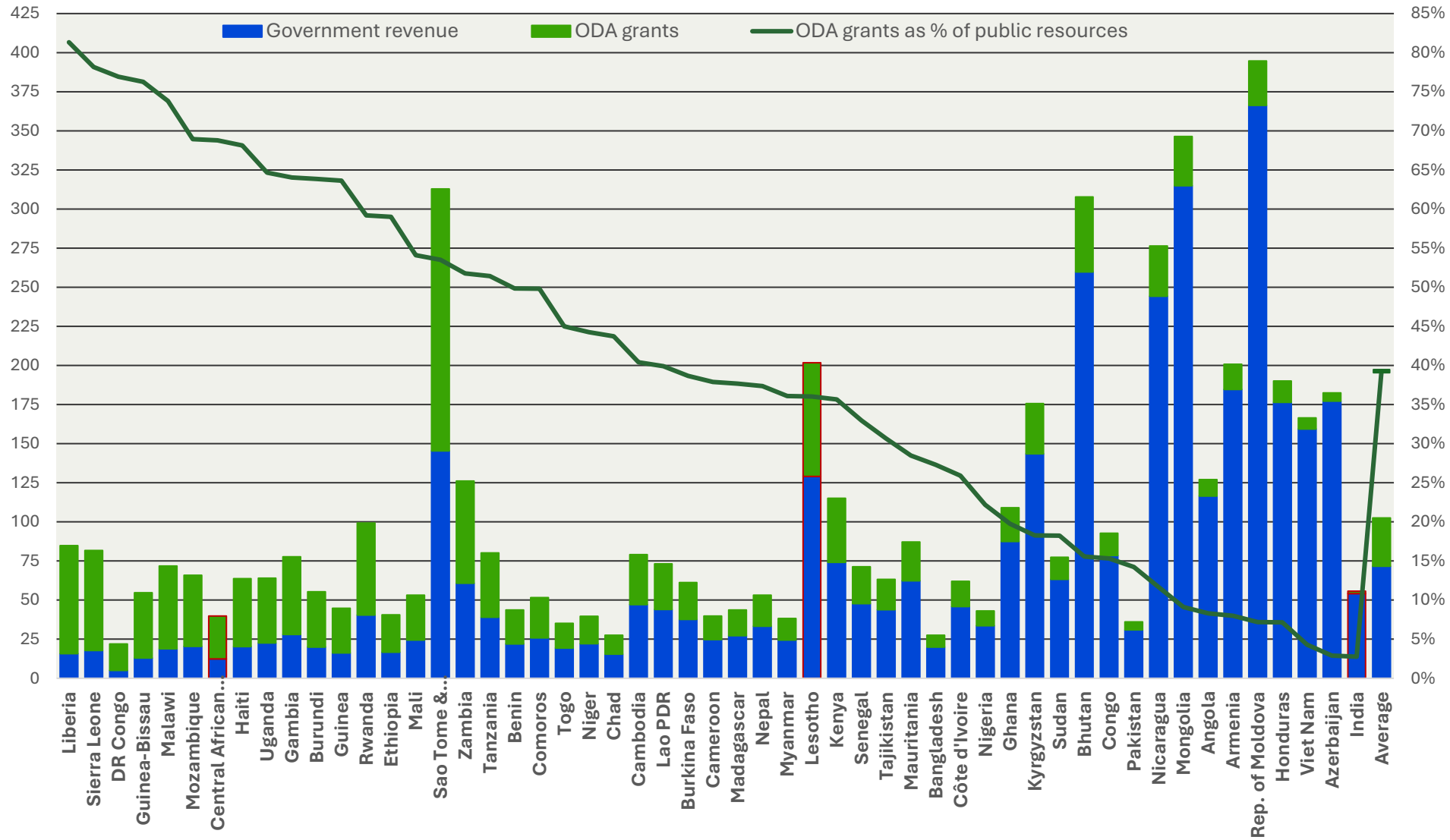
The dependence on ODA subsidies for public finances varies greatly between low-income nations. In 16 countries, more than a third of the total public funds for government functions came from development cooperation grants, while in other nation states government revenues from domestic sources predominate.

In terms of the share of ODA grants, the Central African Republic leads the way with a value of over 60%. But many other countries are highly dependent on grants from development cooperation to finance public services.

The three nations outlined in red were not included in the sample for the analysis of the statistical relationship between resource use and mortality risk due to special conditions, namely uncertain data (Central African Republic), extremely high HIV prevalence (Lesotho) and extraordinarily high manufacturing capacity of medical devices (India) (see pages 6 to 9).

ODA is irreplaceable: the central role of ODA grants for health

Low-income countries before 2000: government spending and ODA grants for health in the period 2000-2022, mean values in constant int. \$ of 2021

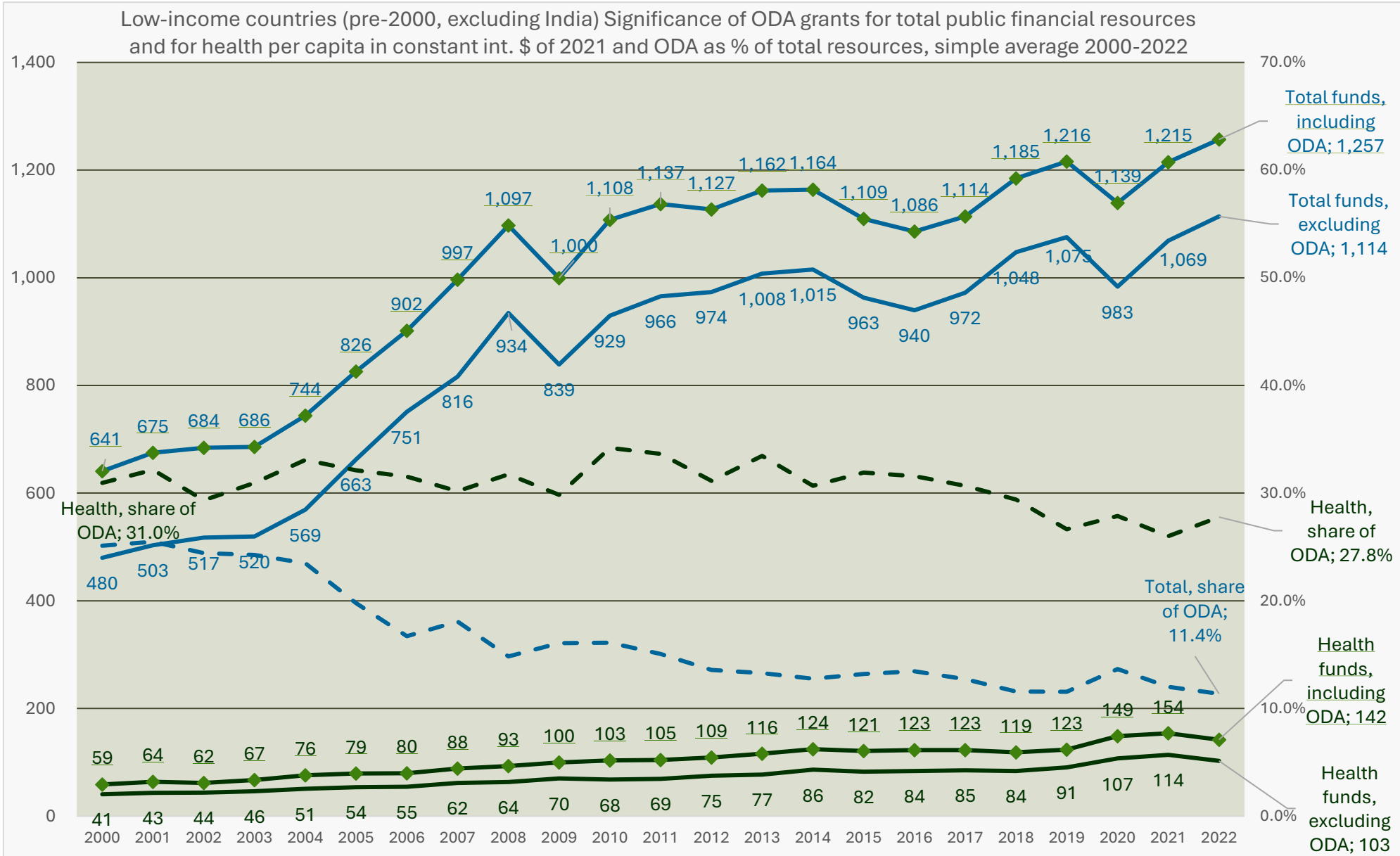


This chart depicts total public expenditure per capita on health, again differentiating between domestic resources and ODA contributions. The line represents the percentage of ODA grants for health in all public resources for health.

In the health sector, the dependence of many low-income countries on ODA grants is even more pronounced than was the case in terms of all public resources. In 18 countries, ODA grants for health accounted for more than half of total public expenditure on health during the period under review. Four nations even exceeded the 75% mark and are therefore extremely dependent on ODA for health.

In 2022, health expenditure covered by domestic public resources was less than \$100 per capita in 38 countries. This is by no means enough to adequately equip the health systems. Thus, at least the 1.6 billion people living there (excluding India) are urgently dependent on international solidarity in order not to die prematurely from preventable or treatable diseases. Even including ODA grants, 27 countries with nearly 1.4 billion people remained below \$100, making short-term strengthening of cooperation essential.

ODA is irreplaceable: ODA remains an important pillar of health financing



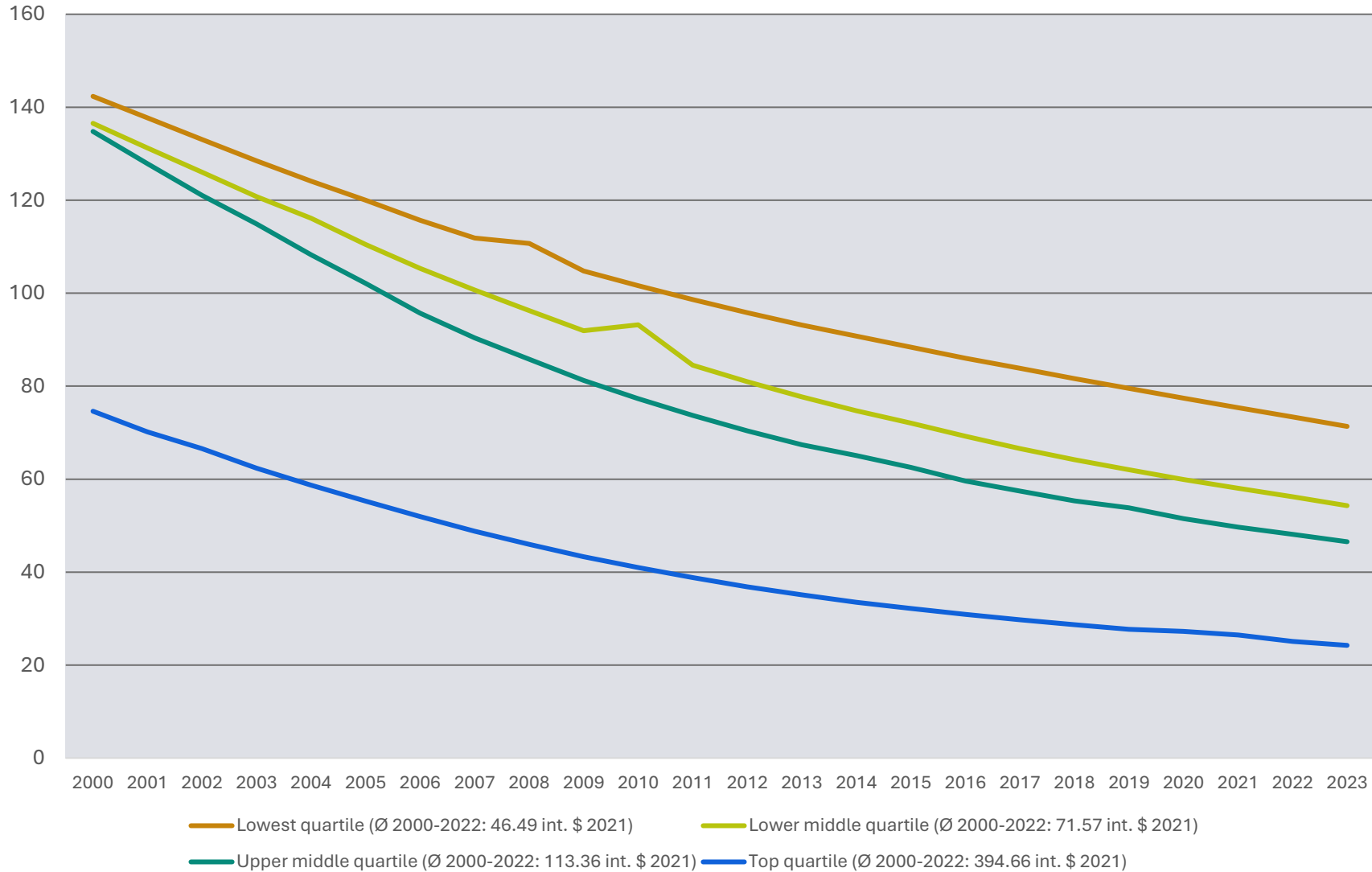
In nation states classified as low-income countries before 2000 (excluding India), ODA for health rose from \$18 billion in 2000 to \$40 in 2013, but stagnated in the period thereafter until 2021. Domestic funds for health also doubled until 2014, stagnated afterwards and only grew again during the pandemic.

The share of ODA funding in public financial resources for health was close to one third for almost two decades but has fallen to less than 30% in recent years.

The share of ODA in the health sector was thus much higher than in the total budget spent on all public services. This is because the ODA share there was only 11% in 2022. The reason is that funds generated from domestic sources also increased by more than 100%, but international cooperation fell behind in relation to the population from 2011 onwards.

ODA is effective: reduction in child mortality and public health expenditure

Infant mortality per 1,000 live births by quartiles of public health expenditure per capita per year in the period 2000-2022 (amounts in constant int. \$ of 2021)



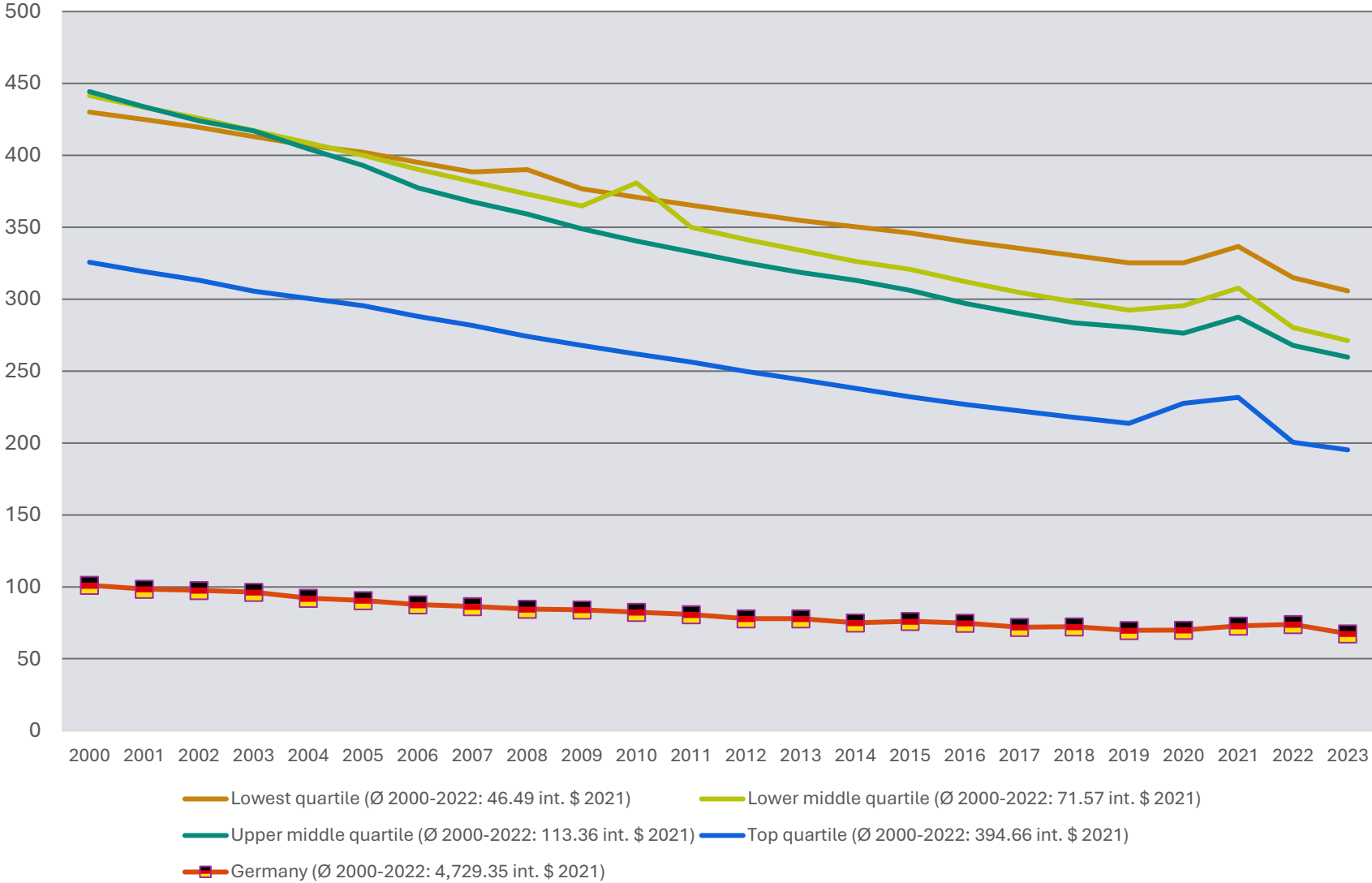
The next four charts look at an analysis of domestically sourced public investment in health and ODA grants on the one hand, and the main indicators of premature mortality risk on the other. In particular, the countries that were classified as low-income nations by the World Bank before the year 2000 are considered. For 50 of these countries, all relevant data for the period 2000 to 2022 could be determined and comparability is not severely limited by extremely high disease burden (HIV infection rate) or other special conditions.

The low-income countries were divided into four groups by splitting by quartiles according to public health expenditure per capita. While child mortality decreased in all groups, there were significant differences in health expenditure.

This correlation suggests that the level of public health expenditure is highly relevant to the level of child mortality in low-income nations. Consequently, the impact of ODA grants is also very important because they make up a significant part of the financing.

ODA is effective: significant reduction in the risk of death in people under 60 years of age

Low-income countries before 2000: Mortality risk below 60 per 1,000 persons by quartiles of public health expenditure per capita per year in the period 2000-2022 (amounts in constant int. \$ of 2021)



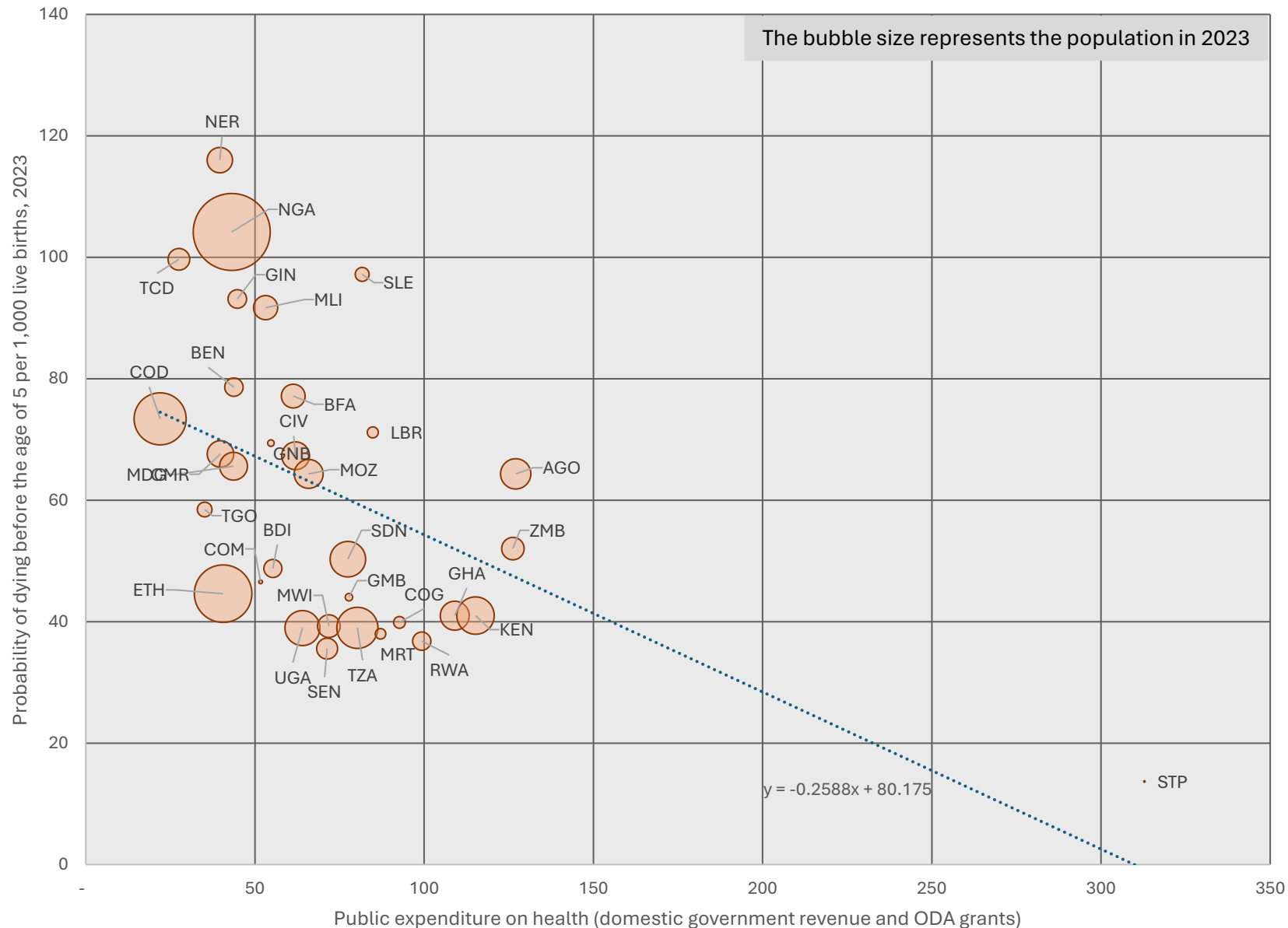
This graph shows the same quartiles of the selected 50 low-income countries graded according to public health expenditure per capita. This time, however, the development of the mortality rate of under 60-year-olds per 1,000 people is considered.

The probability of dying has generally decreased in the period from 2000 to 2023. At the same time, there is also a difference between the quartiles – the higher the public health expenditure of a group of countries, the lower the risk of dying before the age of 60. However, this difference is particularly pronounced between the top two quartiles.

The decrease in the risk of death in Germany was 33%. This reduction was smaller than in the top three quartiles of low-income countries, where there was a reduction of 39-41%. At barely 29%, the probability of death in the lowest quartile of the poorest nations decreased the least.

It should be borne in mind that the large differences in the structural causes of vulnerability to the spread of diseases lead to considerable differences in the financing needs of national health systems. Given the cost of lifelong antiretroviral treatment, HIV infection rates are a major factor. In the middle quartiles, the prevalence was almost twice as high at about 3% of the adult population as in the lowest quartile at just under 1.7%.

ODA is effective: public health expenditure correlates with lower child mortality



This graph demonstrates the statistical relationship between public expenditure on health (x-axis) and the probability of dying before the age of 5 (y-axis) for the low-income African countries in the sample.

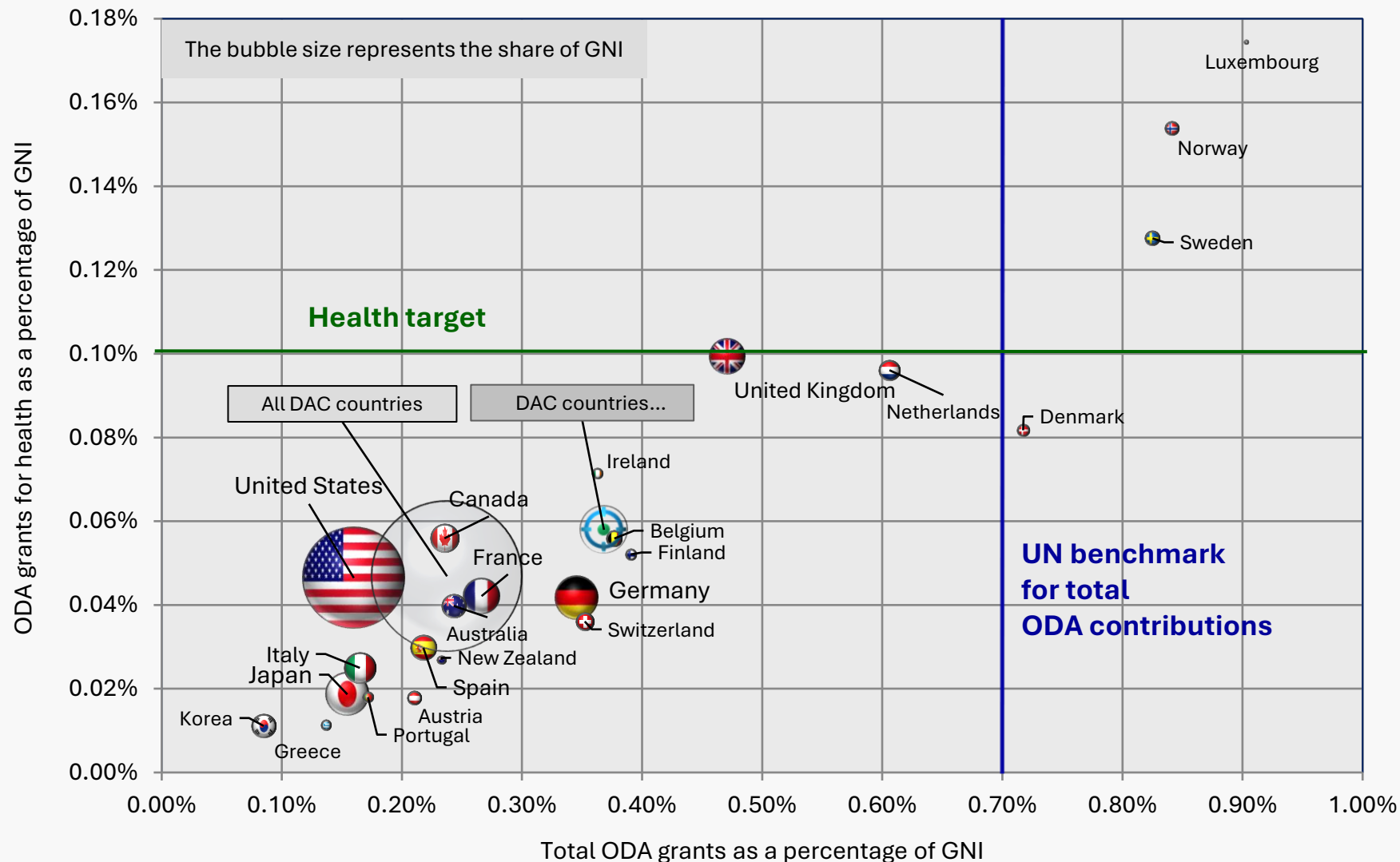
The very strong correlation that higher health expenditure from domestic public government revenues and ODA contributions is accompanied by a decrease in child mortality becomes directly clear.

Increasing public health spending per capita from \$50 to \$100 can reduce infant mortality by 13 out of every 1,000 live births, although generally only a fraction of the funds are spent on young children. In addition, without exception, all countries with very high infant mortality rates are below the \$100 mark in health expenditure from public funds. This means that from a minimum level of health expenditure, it can be possible to avert extremely high mortality rates among young children.

This evidence is a key argument for health-related development cooperation. ODA for health is an important pillar of public health spending in low-income countries.

ODA is affordable: missed target values despite proven effect

ODA grants of DAC countries in relation to economic capacity measured by gross national income (GNI) in the period from 2000 to 2023



In relation to economic capacity, the financial efforts of most donor countries for development cooperation as a whole and for cooperation in the health sector remained far below the required contribution levels. The chart shows this on a constant US\$ (2023) basis for better comparability.

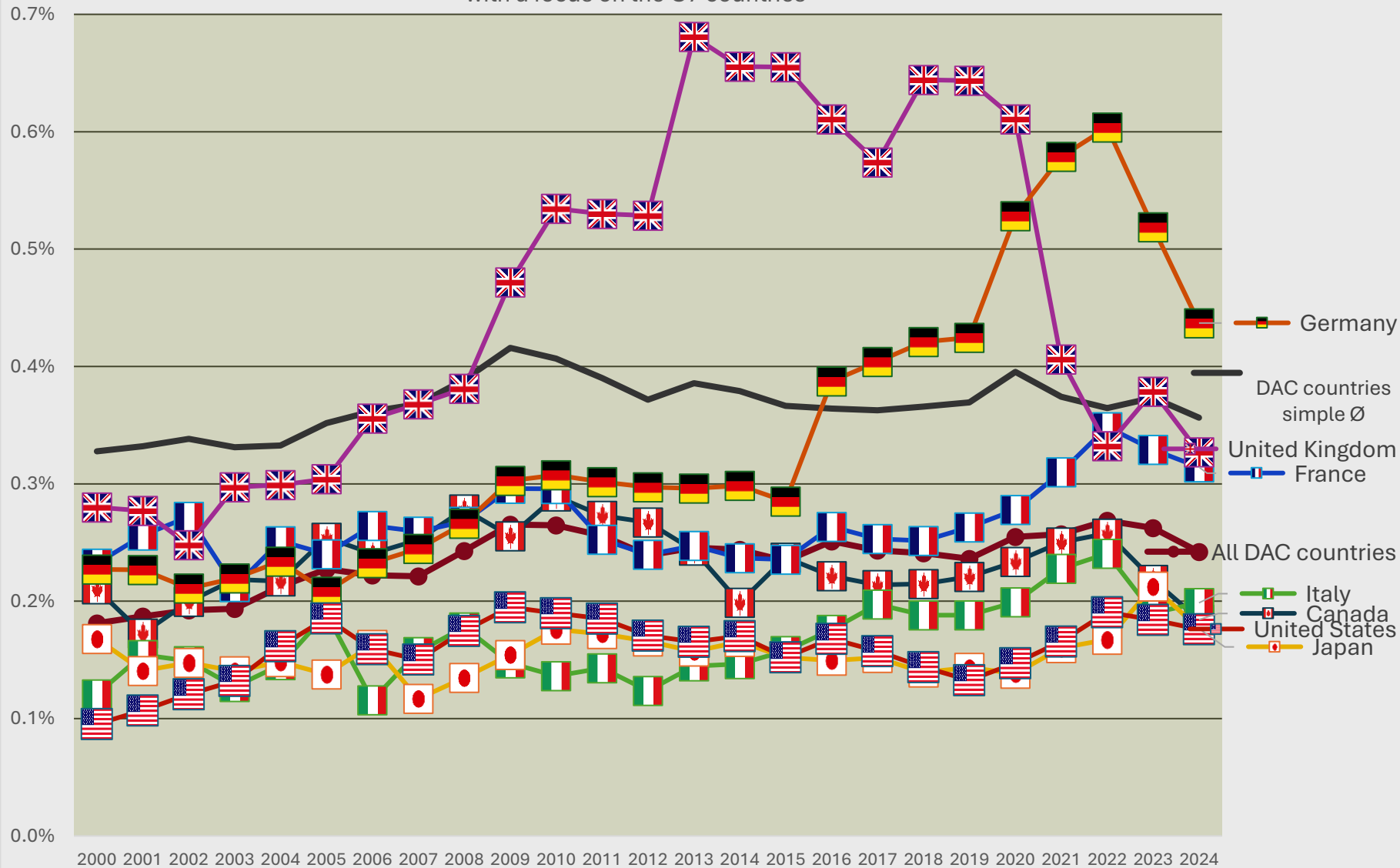
Despite the proven effectiveness of ODA in the health sector – for example, in the case of infant mortality and mortality of people under 60 years of age – the contributions of donor countries have remained far too low, with few exceptions.

Only four countries reached or exceeded the 0.7% target. The WHO recommendation to spend at least 0.1% of GNI on health-related development cooperation, which has been in place since 2001, was also achieved by only four nations. As a consequence, ODA grants should have been much higher since 2000, which could have led to much fewer deaths due to the effectiveness of ODA spending in low-income nation states.

On average, DAC countries spent only 0.24% of their economic capacity on real transfers in all areas of development and, at 0.047% of GNI, provided less than half of the required resources for health.

ODA is affordable: ODA contributions from the G7 countries in real terms

Total real transfers of ODA grants in relation to gross national income, 2000-2024
with a focus on the G7 countries



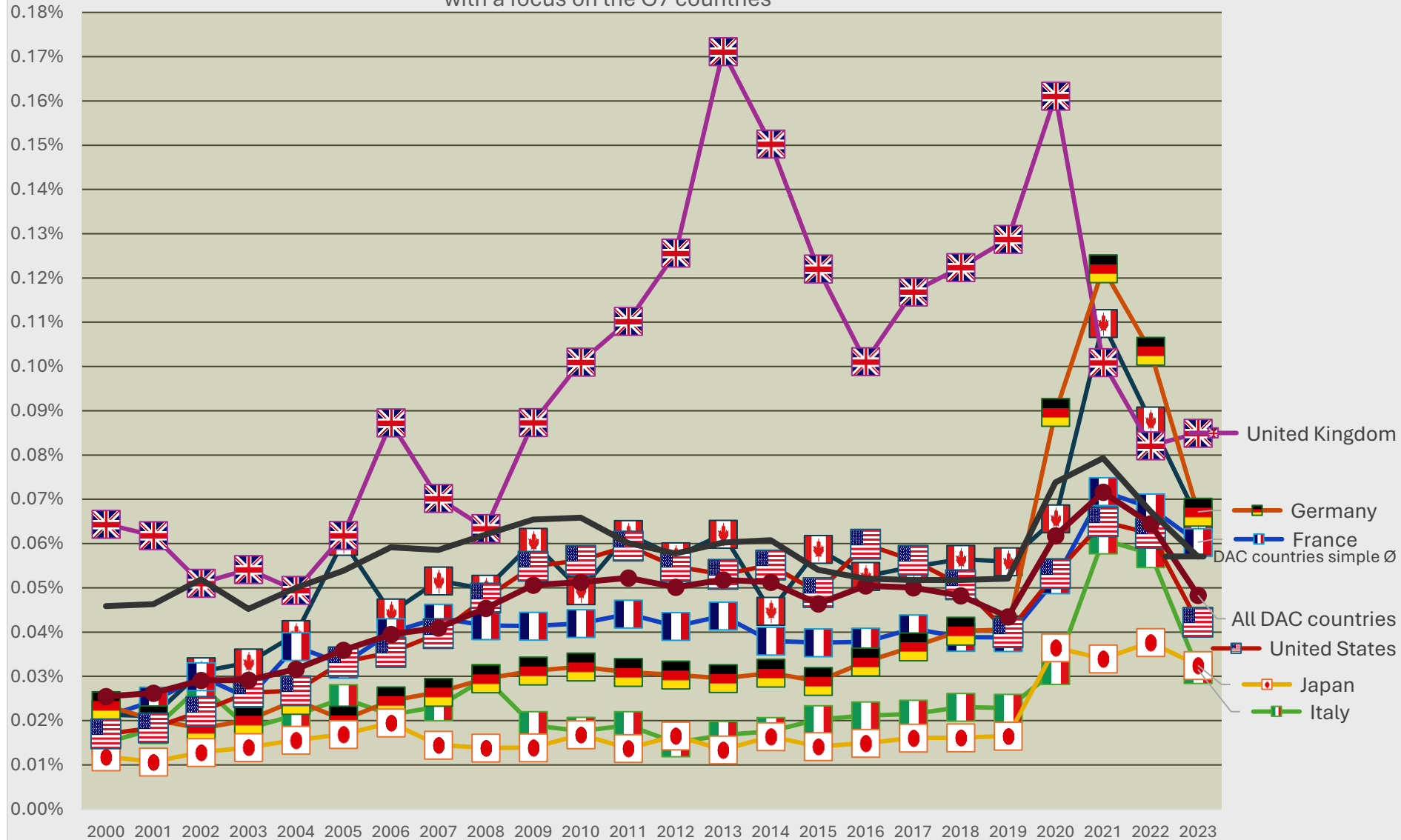
This graph compares the ODA grants of the G7 countries over the period from 2000 to 2024. The upper end of the graph marks the target level of 0.7% of gross national income agreed in 1970 within the framework of the United Nations.

In this context, the real transfers of ODA grants, which exclude expenditure for refugees in the donor countries, loans, imputed student costs, debt relief and administrative costs, are used for the calculation. If you exclude these officially creditable but questionable financing variables, no G7 nation has ever reached the 0.7% target.

Only Germany during the Covid-19 pandemic and the United Kingdom before the pandemic came close to meeting the target for a few years. Large economies such as the USA and Japan have particularly low spending levels, which is especially problematic for ODA financing.

ODA is affordable: ODA for health by the G7 countries compared to the WHO recommendation

ODA grants for health in relation to gross national income, 2000-2023
with a focus on the G7 countries



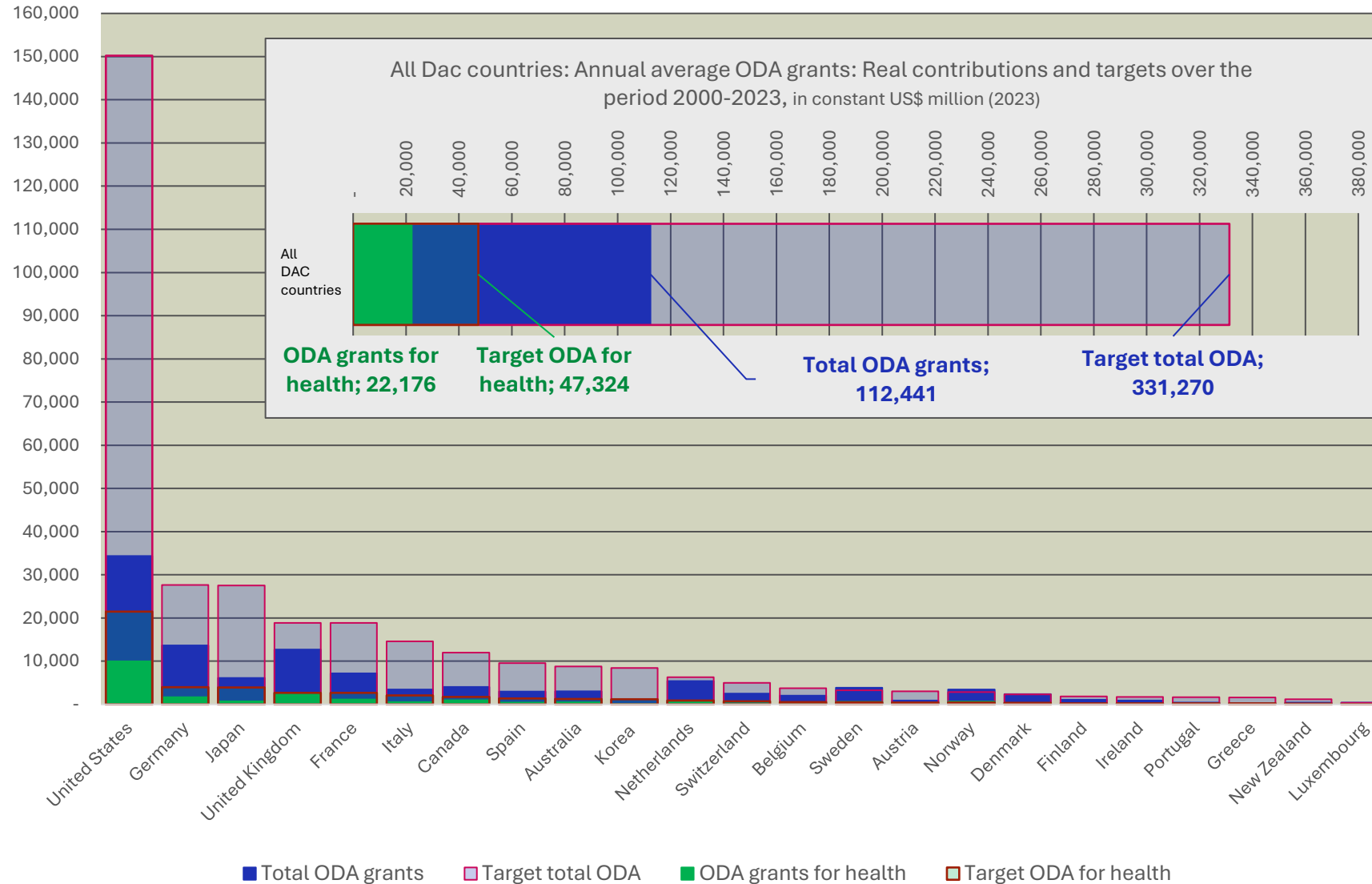
Analogous to the previous chart, the performance of the G7 countries in the period 2000 to 2023 is considered. However, this consideration focuses on ODA contributions for health.

With regard to the WHO recommendation to spend at least 0.1% of GNI on health-related development cooperation, several observations need to be made. On the one hand, the United Kingdom has even significantly exceeded this target level in several years, while the majority of G7 nations are far below the WHO recommendation. On the other hand, there was a significant increase over the course of the COVID-19 pandemic, as countries such as Germany and Canada surpassed the target for a few years.

Identical to the total ODA grants, the G7 countries' expenditure on health-specific development cooperation should have been much higher, which would have made it possible to make even greater progress in improving the life chances of the poorest parts of humanity.

ODA is affordable: why too little ODA contributions cost lives

Annual average ODA grants: Real contributions and targets in the period 2000-2023, in constant US\$ million (2023)



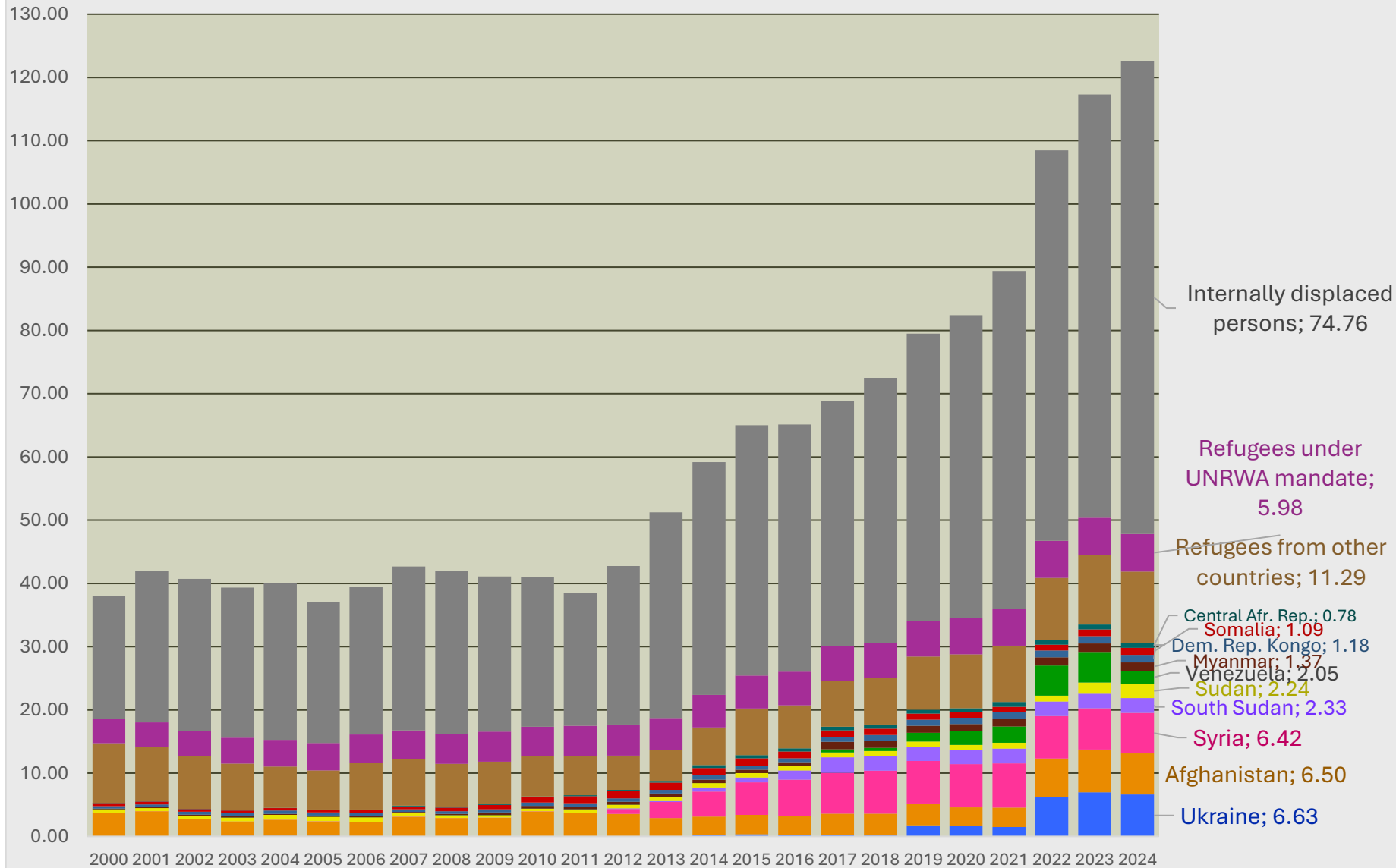
This graph presents a comparison between ODA grants for health (green) and total ODA funding (blue) with the contributions to be paid for development cooperation according to the 0.7% target and 0.1% recommendation.

If all DAC countries (Development Assistance Committee of the OECD) had reached the minimum level of 0.7% of GNI decided by the United Nations, the total net transfers in the form of grants would have been almost three times higher than the sums raised.

And if the WHO's recommended contribution level had been met, more than twice as much funding could have been used. This would have resulted in much higher public spending on health in ODA recipient countries, especially low-income nation states. Since this expenditure has been shown to be associated with lower mortality among children and those under 60, it can be assumed that millions of premature deaths could have been prevented.

ODA is responsible: sharply increasing number of refugees and displaced people

Cross-border refugees and internally displaced persons, showing the 10 most important countries of origin



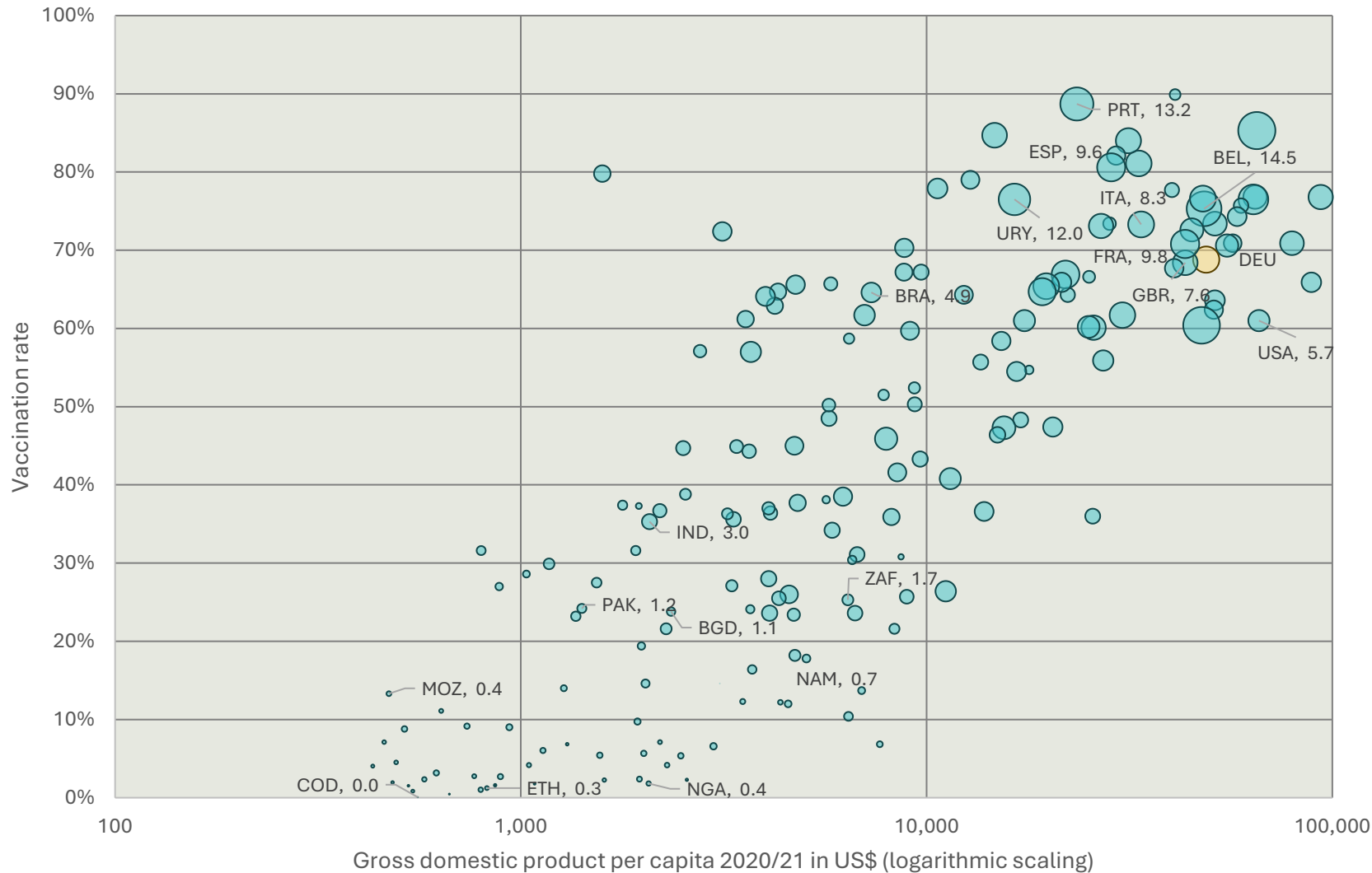
This graph shows the extreme increase in the number of internally displaced persons and cross-border refugees worldwide since 2000. From a starting level of less than 40 million people on the move, this figure has increased to over 120 million by 2024. As a result, more than three times as many people are currently fleeing globally than was the case 24 years ago. Subsequently, the needs in the field of humanitarian aid have increased drastically.

For this reason, it is responsible to step up contributions to both humanitarian aid and development cooperation in order to meet these increased needs and to address the root causes of displacement, such as conflict and disaster.

Expanding spending in these areas should be seen as a perception of interpersonal and solidarity-based responsibility, instead of arguing with the prevention of refugee and migration movements.

ODA is responsible: coverage and protective effect of Corona vaccination campaigns

Deaths avoided through corona vaccinations in relation to per capita income and vaccination rate



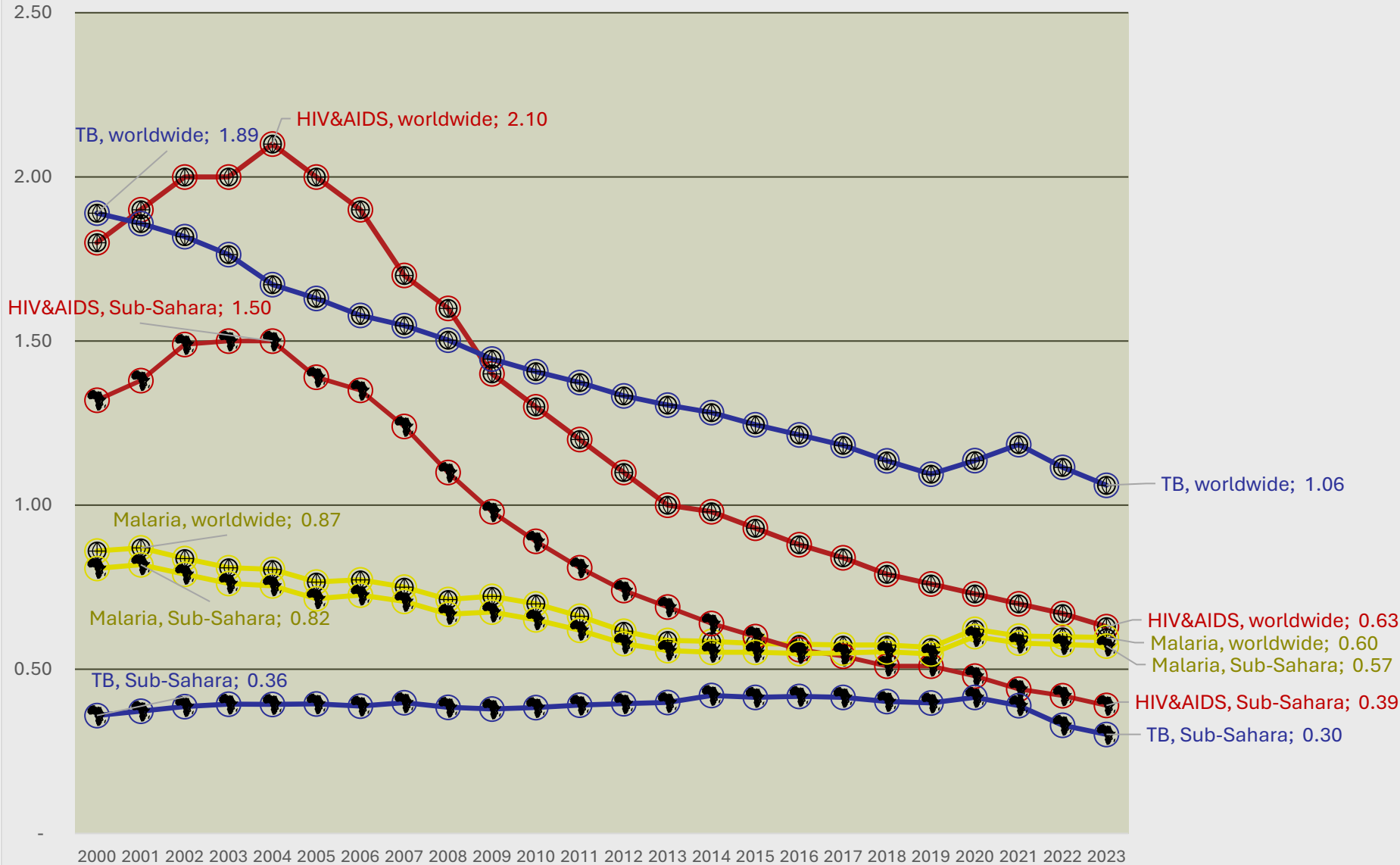
The estimate of avoided deaths in the first year of COVID-19 vaccinations is based on excess mortality data as a measure of the real extent of the COVID-19 pandemic. In total, around 19.8 million deaths were prevented in the period from 08.12.2020 to 08.12.2021, which corresponds to 63% of the number of 31.4 million COVID-19-related deaths that would have occurred without vaccinations.

The rate of access and the prevention of deaths in relation to the size of the population depended very much on the income levels of the countries, with the implementation of other protection measures and the age structure having a significant influence on the result as well. If at least the WHO recommendation to reach 40% of the population had been implemented, almost another 600,000 deaths could have been avoided in poorer countries. This means that more lives could have been saved if vaccines had been distributed more quickly in many parts of the world and if vaccine uptake had been improved worldwide. The economic disadvantage thus led directly to the exclusion of life-saving measures.

Moreover, there is a responsibility to use more financial resources to improve health conditions in the disadvantaged regions of the world in order to cushion the negative effects caused by the pandemic and to be better prepared against disease outbreaks worldwide.

ODA is responsible: deaths as a result of the epidemics of HIV/AIDS, TB and malaria

Deaths caused by HIV&AIDS, TB and malaria in millions, 2000-2023

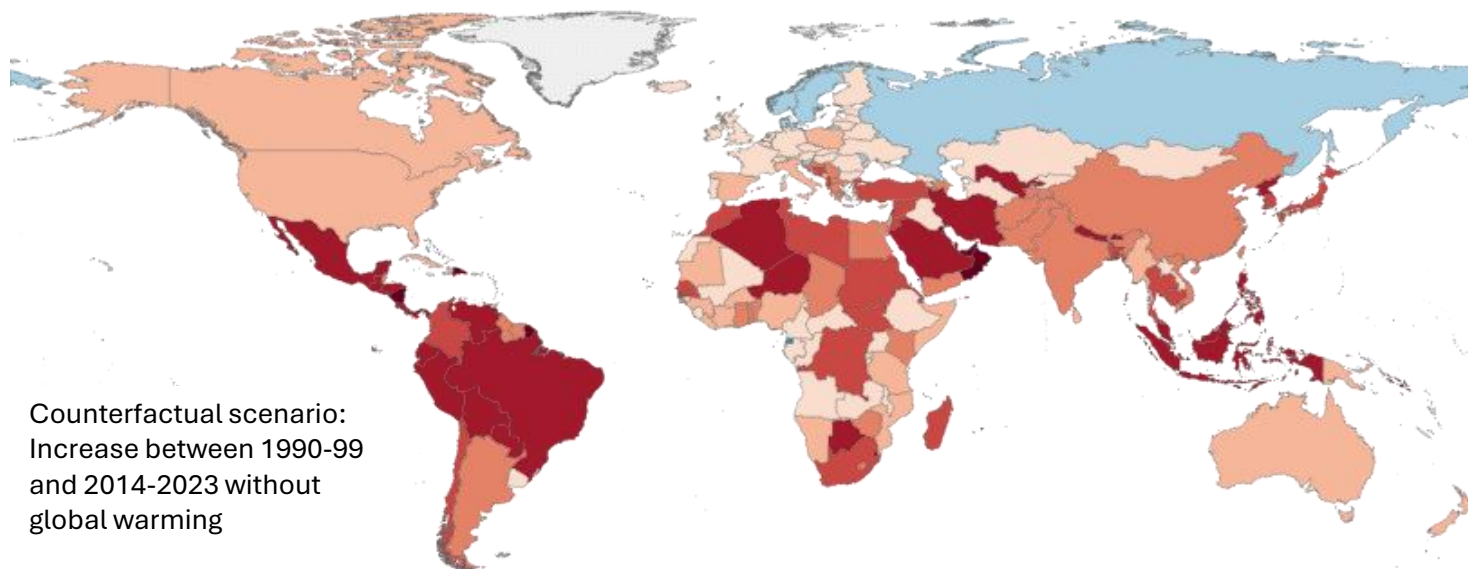
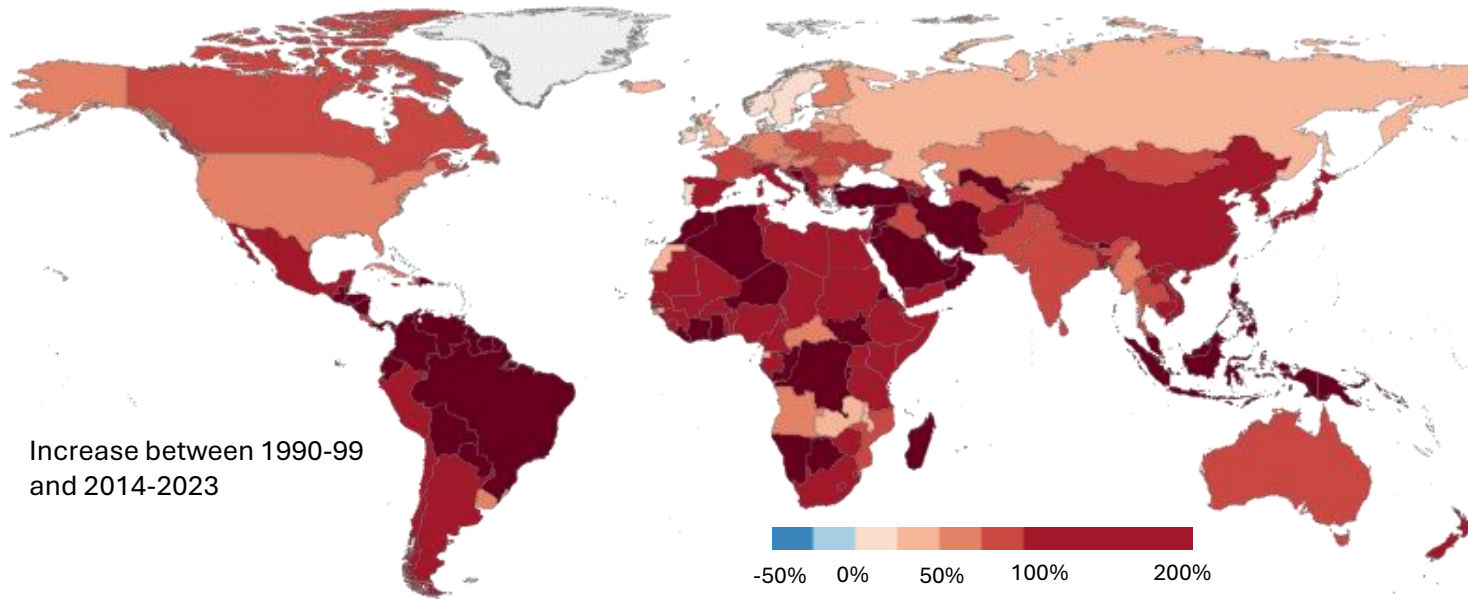


This graph clearly displays that enormous progress has been made in reducing deaths from HIV/AIDS, tuberculosis and malaria since 2000.

The Global Fund alone is estimated to have saved the lives of 65 million people through its life-saving investments. The containment of the three epidemics, and in particular the reduction of mortality from HIV/AIDS, malaria and tuberculosis, would not have been possible without strengthening international cooperation and the associated use of ODA grants.

However, death rates are still well above the levels that would be necessary to achieve the internationally agreed targets to end the three epidemics. This results in a fundamental responsibility to substantially increase ODA grants for global efforts to combat HIV/AIDS, tuberculosis and malaria. Otherwise, there is a risk of a clear failure to meet target 3.3 of the Sustainable Development Goals (SDGs), which aims to end the epidemics of AIDS, tuberculosis and malaria by 2030, among other things.

ODA is responsible: the importance of increased climate finance



The top chart shows the percentage change in annual heat-related deaths among adults over 65 years of age in the period 2014-2023 compared to the period 1990-1999. The world map below presents the changes that would be expected if the global temperature remained unchanged, i.e. without the effects of global warming.

Rising temperatures and an aging population led to a 106% increase in average annual heat-related deaths among adults over the age of 65 between 1990-99 and 2014-23, 139% higher than the 44% increase expected if temperatures had not changed from baseline levels. In 2023, the number of heat-related deaths in this age group reached the highest level recorded, 167% higher than in the 1990-99 period and more than double the 65% rise that would have been expected if temperatures had not changed since the 1990s.

Germany's contributions to international public climate finance are better than those of most industrialized countries but are still classified as "inadequate". Germany has pledged to step up its climate finance, but contributions to date are low compared to its fair share. To improve its rating, Germany must raise its contributions to international climate finance by a factor of three and, above all, stop financing fossil fuels abroad.

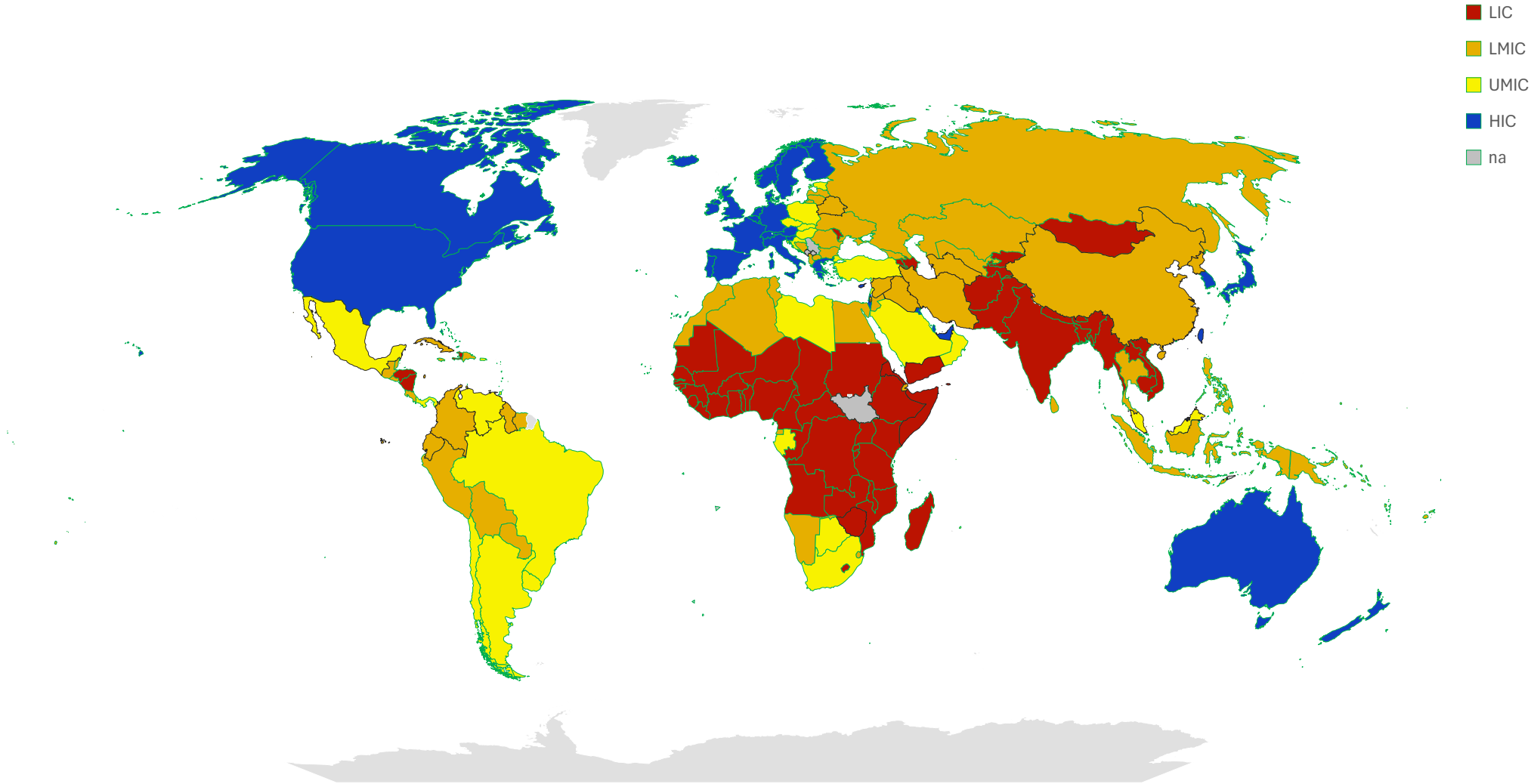
The global challenges of global warming and climate change can only be tackled if more is done worldwide. It is therefore responsible to increase investment in climate finance and ODA.

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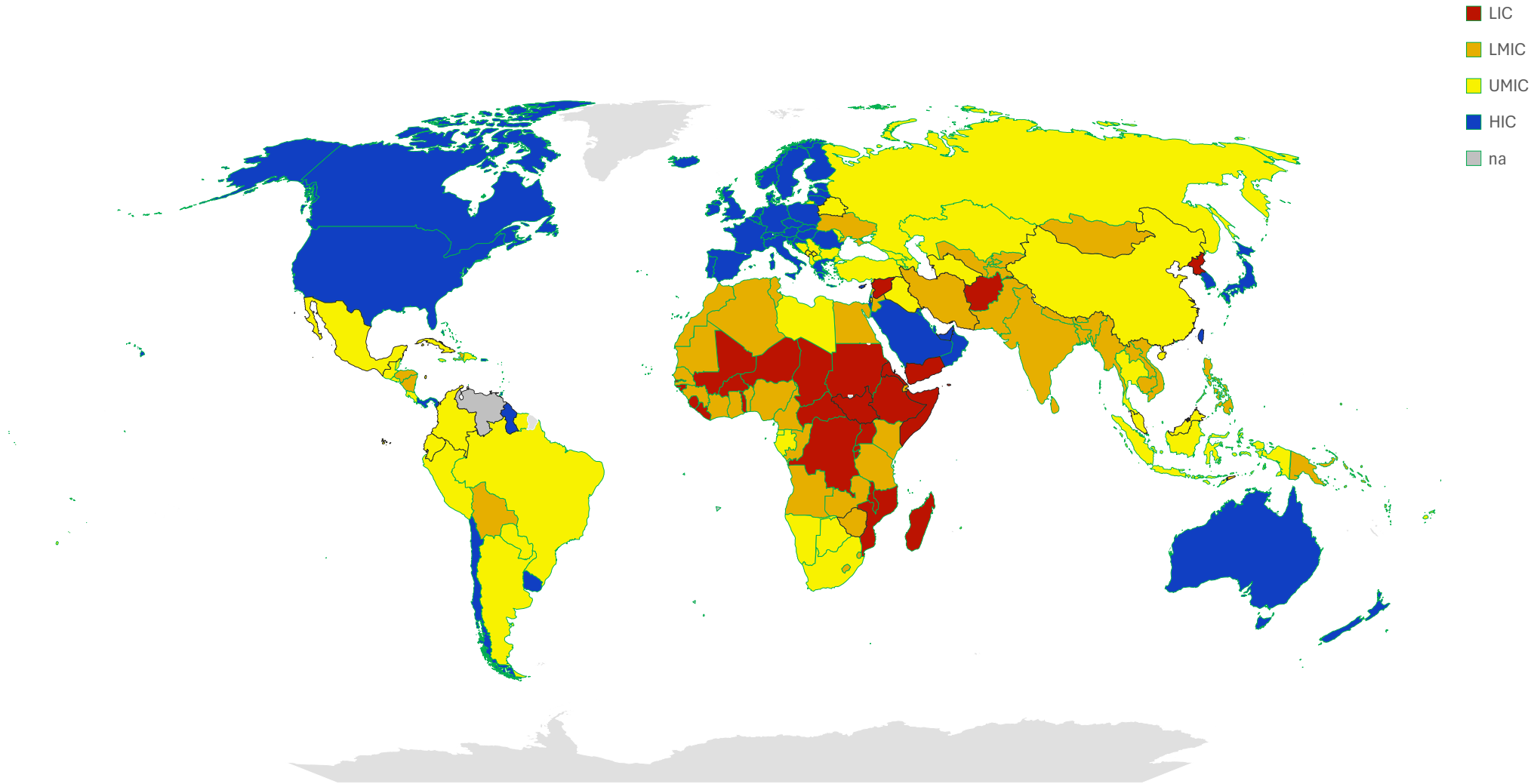
World Bank Analytical Classifications: Countries by Income Groups before 2000

Countries by Income Groups before 2000, grey borders indicate that not all required data are available



World Bank Analytical Classifications: Countries by Income Groups in 2022

Countries by Income Groups in 2022, grey borders indicate that not all required data are available



Imprint

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