OVERVIEW

Germany’s engagement in global health has increased steadily over the past decade, and it is now Europe’s second largest donor to global health, after the UK. Its global health spending has tripled since 2000 to an annual contribution of US$964.7 million (€692.8 million) in 2009. Its strategic focus is fighting HIV/AIDS, improving sexual and reproductive health (SRH), and strengthening health systems. Bilateral assistance accounted for 44% of health expenditures in 2009 (Figure 1), and the rest was channeled through multilateral organizations. About half of Germany’s multilateral health aid in 2009 (US$285.8 million, €200 million) went to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Global health strategic priorities are defined by the Ministry for Economic Cooperation and Development (BMZ). The governing conservative-liberal coalition, which took power in September 2009, is placing a stronger focus on bilateral aid, with the aim of reducing development assistance to multilateral organizations to one-third of total official development assistance (ODA) over time.¹

GLOBAL HEALTH PRIORITIES AND STRATEGY

Germany’s overall global health strategy is guided by a human rights-based approach, which aims to integrate human rights norms into every stage of a global health project.

In its support for health systems strengthening, Germany finances projects that support the development of national health strategies, and the strengthening of human resources for health. It also supports the development of social security systems (e.g., community-based public health insurance). In 2007, Germany co-initiated “Providing for Health,” a G8 initiative to improve health systems financing, and supported the launch of the International Health Partnership (IHP+), a multi-donor effort to harmonize donor funding for health.

In HIV/AIDS prevention and treatment, Germany finances HIV prevention campaigns and the provision of free HIV tests and free or affordable antiretroviral therapy. Its support to partner countries has a strong focus on integrating HIV/AIDS services into other programs, i.e., basic health care, family planning, and maternal health programs. Germany is also the third largest donor to the Global Fund.² Bilaterally, Germany supports countries in applying for and implementing Global Fund grants through a technical support program called the BACKUP Initiative (BACKUP stands for Building Alliances, Creating Knowledge and Updating Partners).

The promotion of SRH and rights is interlinked with Germany’s HIV/AIDS strategy.³ Germany funds the supply of modern contraceptives, improved access to family planning services, and qualified medical assistance for abortions and at birth. Germany supports implementation of health programs through collaboration with non-governmental organizations (NGOs), the private sector, and churches.

GLOBAL HEALTH FUNDING

Germany’s overall ODA in 2010 reached a share of only 0.38% of its gross national income (GNI). Germany thus failed to reach the European Union (EU) interim goal of spending 0.51% of its GNI on ODA by 2010, as laid out in the European step-by-step plan to reach the 0.7% target by 2015.

Nevertheless, Germany’s health ODA has doubled since 2005 and more than tripled since 2000, making Germany the second largest European donor to health in absolute terms (US$964.7 million, €692.8 million in 2009). However, Germany’s contribution to global health as a percentage of GNI is still among
the lowest in Europe, with health ODA amounting to 0.032% of GNI, compared to, for example, 0.076% in the UK. Figure 1 summarizes commitments for bilateral and multilateral development assistance in health as reported to the Organisation for Economic Co-operation and Development’s Development Assistance Committee (OECD DAC).6

**Figure 1: Share of health ODA, European DAC members in 2009**

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<tr>
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<th>Multilateral</th>
<th>Bilateral</th>
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<tr>
<td><strong>UK</strong></td>
<td>24%</td>
<td>44%</td>
</tr>
<tr>
<td><strong>Brazil</strong></td>
<td>14%</td>
<td>56%</td>
</tr>
<tr>
<td><strong>Norway</strong></td>
<td>8%</td>
<td>92%</td>
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<tr>
<td><strong>Sweden</strong></td>
<td>7%</td>
<td>93%</td>
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<tr>
<td><strong>Spain</strong></td>
<td>7%</td>
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<tr>
<td><strong>Netherlands</strong></td>
<td>10%</td>
<td>90%</td>
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<tr>
<td><strong>Others</strong></td>
<td>15%</td>
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*Others: Austria, Belgium, Denmark, Finland, Greece, Ireland, Luxembourg, Portugal and Switzerland

**Bilateral Spending**

The bilateral share of health ODA (US$424.6 million, €304.9 million in 2009) has ranged from a low of 43.5% (2005) to a high of 59.9% (2006) over the past five years. While funding allocation decisions are made by the BMZ, bilateral funding is primarily channeled through the development bank KfW and the development organization GIZ (see below). KfW and GIZ fund projects and sector-wide approaches (SWAps). A large share of funding is allocated through regional quotas, while a smaller share is allocated to sectoral focus areas, including health. Germany also provides bilateral support to the International Planned Parenthood Federation, the International Partnership for Microbicides, and the Global Polio Eradication Initiative.

Germany focuses its bilateral development cooperation in health on sixteen partner countries; these key partner countries and other countries where Germany implements health projects are shown in Figure 2. The recent “peer review” of Germany by the OECD DAC welcomes this focus on priority countries and sectors. However, it criticizes a general lack of a “clear strategic purpose” in the selection of countries and sectors. The review also shows that only 40% of bilateral development assistance is allocated to Germany’s partner countries, while 60% is allocated to non-partner countries (among them many middle-income countries). Finally, the review found that Germany strongly ties its development assistance to the procurement of German services: 69% of funding allocated for technical cooperation was “tied aid,” which is above the OECD DAC average of 49%.6

**Figure 2: Countries receiving bilateral health sector support from the BMZ through KfW or GTZ**

**Multilateral Spending**

In 2009, Germany’s multilateral health ODA spending was US$540.1 million (€387.8 million), representing 56% of total health ODA. Major recipients of funding were the Global Fund, the EU, the World Bank Group, WHO, UNFPA, and the GAVI Alliance.

The current government’s commitment to reducing multilateral assistance to one-third of total ODA draws on a recommendation by parliament’s Budget Committee in 1993. Previous governments did not follow this recommendation between 1998 and 2009, but the conservative-liberal government’s coalition treaty explicitly mentioned it. The government wants to channel more money bilaterally to increase political control of how aid is spent. This commitment will have implications in the health arena, as it will be challenging to reach the objective of channeling two-thirds of funding bilaterally unless there is significant budget growth or unless commitments to large multilateral recipients (e.g., the Global Fund) are reneged on.

**GLOBAL HEALTH DECISION-MAKING**

Figure 3 shows the key actors and institutions involved in global health decision-making in Germany.

Overall policy and decision-making authority rests with the Federal Chancellor. The current Chancellor, Angela Merkel, a member of the Christian Democrats (CDU), had a strong hand in doubling Germany’s contribution to the Global Fund in 2008; as host of the 2007 G8 summit in Heiligendamm, Germany, Merkel committed US$5.47 billion (€4 billion) through 2015 to fighting infectious diseases. The Chancellor’s Cabinet is guided by a strong “departmental principle,” giving ministers leverage to develop policies that fall under their functional responsibility.

Germany’s global health policy is driven by the Federal Ministry for Economic Cooperation and Development (Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (BMZ), which formulates and oversees German development
policy and financing. The current Federal Minister of Economic Cooperation and Development, Dirk Niebel, who took office in October 2009, is a member of the Liberal Democrats. The Health and Population Policy division within the BMZ develops Germany’s global health strategy, interfaces with multilateral institutions in health and advises on bilateral health programs. BMZ leadership and its regional divisions are responsible for allocation of Germany’s bilateral development assistance for health (see Figure 4). The role of other ministries in the development of Germany’s global health policy is limited to specific functions:

- The **Federal Foreign Office** ensures that global health policy is aligned with Germany’s overall foreign policy and represents Germany in global health discussions in the context of intergovernmental processes and the United Nations. The Foreign Office is responsible for 9.0% of overall ODA (US$1.09 billion, €782.2 million in 2009), most of which is focused on humanitarian aid.

- The **Federal Ministry of Health** is primarily responsible for domestic health care. It also represents Germany at the WHO, where it holds a seat on the Executive Board (2009–2012). The Ministry of Health’s limited influence on global health is underscored by the fact that it was responsible for only 0.3% of overall ODA in 2009 (US$34.8 million, €25 million in 2009).

- The **Federal Ministry of Education and Research** touches on global health through its international cooperation on health research and development, and life sciences. The Ministry of Education was responsible for 0.8% of overall ODA in 2009 (US$102.1 million, €73.3 million in 2009). In October 2010, it announced a new funding window of €20 million over four years for health product development partnerships.

**Development Agencies**

While the BMZ is responsible for global health policy formulation and strategy development, several other development institutions administer technical and financial assistance.
**Technical cooperation** refers to German technical assistance to partner countries. Since January 2011, the agency responsible for technical cooperation is the German Agency for International Cooperation, officially called Gesellschaft für internationale Zusammenarbeit (GIZ). GIZ is a result of a merger between the German Technical Cooperation agency (Deutsche Gesellschaft für technische Zusammenarbeit, GTZ), the German Development Service (Deutscher Entwicklungsdienst, DED), and Capacity Building International (Internationale Weiterbildung und Entwicklung, Inwent). The aim of the merger is to improve coordination with BMZ and maximize operational efficiency.

The new GIZ takes over GTZ’s employees (about 15,000) working in 130 countries, who advise partner governments and provide technical assistance. It also continues to act as a technical advisor to the BMZ in policy and strategy development. Through its integration of the DED and Inwent, the GIZ also deploys technical experts to partner countries, engages in human resource development (e.g., providing advanced training), and organizes conferences on development issues. In line with Germany’s priorities, the GIZ’s health-related activities will continue to focus on health systems strengthening, HIV/AIDS, and SRH. Fiduciary and strategic oversight of the GIZ lies with the BMZ, which chairs GIZ’s supervisory board.

**Financial cooperation** is implemented by the KfW Entwicklungsbank—a development bank and a member of KfW banking group), responsible for bilateral financial cooperation and providing grants and loans to partner country governments. While financing provided by KfW Entwicklungsbank is supervised by the BMZ to secure alignment with BMZ priorities, the bank is responsible for the actual grant and loan making. In 2008, KfW’s portfolio included 1,911 projects in more than 110 countries. In 2009, its commitments to health totaled US$318.9 million (€229 million), representing 7% of total KfW commitments (US$4.85 billion, €3.48 billion).

The Deutsche Investitions-und Entwicklungsgesellschaft (DEG), also a member of the KfW banking group, finances private sector investments in developing and transition countries. In 2008, US$76 million (€40 million), or 3% of total DEG commitments, were allocated to health. Even though no new commitments were made in the health sector in 2009, DEG has announced to expand its engagement in this field within the next years.

Oversight of the entire KfW banking group, to which KfW Entwicklungsbank belongs, lies primarily with the Ministry of Economics and Technology, but the Development Minister is a member of the KfW banking group’s supervisory board. Strategic oversight of KfW Entwicklungsbank lies with the BMZ.

**Parliament**

While Germany’s global health policy is set by the BMZ, parliament has a variety of opportunities to influence and scrutinize policy formulation and implementation, including via the federal budget process (which includes Germany’s allocation for international development and health). While the Plenary is the key forum for parliamentary debate, most of the parliament’s work takes place in committees.

The Committee on Economic Co-operation and Development (Ausschuss für wirtschaftliche Zusammenarbeit und Entwicklung, or AWZ) is made up of 24 members of parliament (MPs) and focuses on development issues, including health. MPs can submit motions to the government, in which they can request that the government take action on a specific issue. They can also
issue formal requests for information and they can question the Parliamentary State Secretary of the BMZ, who represents the ministry during committee sessions. The AWZ’s Health in Developing Countries Subcommittee (established in 2010, with nine members) meets once a month to discuss global health issues in more detail.

The government’s proposal for the annual development budget, which includes global health spending, is also debated in the AWZ. Each party group has the right to submit amendments to the development budget; the AWZ votes on these amendments, which are then sent as recommendations to the Budget Committee (see Figure 5) for discussion and decision, before a vote in Plenary.

The Foreign Affairs Committee, the Health Committee, and the Committee on Human Rights and Humanitarian Aid at times also discuss health issues, but to date their influence on Germany’s global health policymaking has been small.

Civil Society
German development NGOs coordinate their activities through the influential umbrella association VENRO (which stands for Verband Entwicklungspolitik Deutscher Nichtregierungsorganisationen). VENRO recently founded a working group on global health. The German NGO community includes a strong HIV/AIDS lobby organized in the alliance Action against AIDS Germany, which lobbies political decision-makers and has played an important role in achieving and maintaining Germany’s commitment to the Global Fund. Health systems strengthening and SRH are further areas of focus for the NGO community. Additionally, faith-based NGOs, linked to the Catholic and Protestant churches, have traditionally been important and influential players in Germany’s development dialogue.

Development NGOs regularly interact with the BMZ and Parliament and are often invited to parliamentary hearings and government consultations, such as to the BMZ Roundtable on Global Health. However, NGOs have at times expressed frustration about their limited inclusion in strategic discussions.

BUDGET PROCESS
Up until 2010, the government drafted the budget in a bottom-up approach. From 2011, the Finance Ministry employs a top-down approach. The budget process follows an annual cycle. The Budget Committee is responsible for all decisions that affect the appropriation of funds for global health. It discusses the government’s federal budget proposals, including the development budget. The development budget specifies which funds are allocated to different regions (it does not break down allocation by sectors). Each party group appoints a rapporteur for the section of the budget dealing with development (the so-called Einzelplan 23), which includes global health. The rapporteurs are in charge of negotiating and finalizing the development budget draft before it goes to final vote in Plenary. Figure 5 outlines key steps and timelines in the annual budget cycle.
OUTLOOK
Looking to the future, five trends are emerging:

• The global health budget is unlikely to keep growing at previous rates. In fact, given current projections, it is more likely to stagnate or even decline. In July 2010, the government released an unprecedented austerity package to cut overall government spending by €80 billion by 2014. While the development budget was not cut in the 2011 budget process, the five-year financial plan does stipulate cuts to the development budget for 2012 and 2013. These cuts are likely to also affect health spending.

• SRH will receive increased attention and funding. As part of the G8 Muskoka initiative for maternal, newborn and child health, Germany committed an additional €400 million by 2015 (€80 million per year). The government has announced that it will spend half this amount (€40 million annually) on SRH programs, thereby doubling Germany’s SRH funding.11

• It is still unclear how the government’s commitment to increase the bilateral share of aid to two-thirds of all ODA will affect the health sector. Currently more than half of Germany’s global health budget is channeled through multilateral mechanisms, primarily because of the large contribution to the Global Fund (accounting for more than a quarter of Germany’s global health budget). Given that substantial growth in the development budget is highly unlikely, the balance between bilateral and multilateral aid to health could only be significantly shifted if Germany reduced its commitment to the Global Fund. This is unlikely to happen in the short term, given the strong support for the Global Fund at the highest political levels and within civil society in Germany.

• The coalition government has expressed a strong interest in results-based financing (RBF) approaches, which will be tested and integrated into Germany bilateral health programming. It remains to be seen how RBF will be implemented in practice, particularly in the context of health SWAps and budget support, which have been key instruments of bilateral assistance to date.

• Finally, development assistance is being more closely aligned with foreign policy and economic interests. For instance, financial support to German NGOs from the BMZ for their work in Afghanistan will be subject to their collaboration with German institutions, including the military.13 Germany’s private sector will also play a greater role in development programming, which may include an expanded role in health.

REFERENCES
2 In the 2010 voluntary replenishment, the three largest donors were the US, France and Germany. Source: http://www.theglobalfund.org/documents/replenishment/newyork/Replenishment_NewYorkMeeting_Pledges_en.pdf
5 Contributions to international organizations that do not exclusively deal with health are calculated according to the OECD DAC’s methodology.
6 Overall, 23% of Germany’s bilateral ODA was tied, which is above the DAC average of 19%. The DAC countries are Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Japan, Korea, Luxembourg, Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom, United States and the European Union Institutions.

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E2Pi
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The Evidence to Policy Initiative (E2Pi) is a global health policy collaboration between the UCSF Global Health Group and SEEK Development. E2Pi conducts independent analysis and evidence synthesis to inform discussion and decision-making on critical policy and strategic issues in global health.

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