

HEALTH IN DEVELOPMENT COOPERATION AND HUMANITARIAN ACTION

2019 REPORT

HIGHLIGHTS




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Introduction

In June 2018 a motion of censure led to a new socialist government in Spain. To date, its discourse on development aid and its actions have focused on the commitment to strengthen these public policies as part of external action, to provide them with sufficient resources, and to adapt them to the globality and implementation of 2030 Agenda, whose objectives and contents transcend the development cooperation portfolio.

The balance leaves a bitter taste. The main objective was to recover the Spanish Cooperation in terms of both quantity and quality. Well, neither one nor the other has happened. Cooperation policy is far from recovering the institutional, political and budgetary level that should have, without denying the government's effort to be at key international events.

Macroeconomic figures changed from red to green a few years ago, but this change has not been perceived by a large part of the population, nor has it reached those policies whose virtue is to deal with the increasing inequality gap. Spanish Official Development Assistance (ODA) continues to be scarce and in the European back-end, which devalues the image that the government wants to project in major international events. In real terms, ODA falls by almost 3%, which means that the aid effort remains at 0.20%, well below the Development Assistance Committee (DAC) countries average of 0.31%, European donor countries of 0.47% and the 0.7% international commitment.

Regarding health, Spain allocated 61.3 million Euros, 2.47% of total gross ODA, insufficient to help reduce major global health problems. Maternal mortality or preventable deaths of new-borns and children under five, communicable and non-communicable diseases, which affect disproportionately the world's most vulnerable populations, remain a challenge.

The tools to address this, such as universal health coverage, remain underdeveloped and there is a real risk of not achieving the health goals to which the international community committed under the 2030 Agenda. Health inequity remains our greatest global health problem and the most impoverished and vulnerable population continues to have poorer health.

On the other hand, the Report incorporates new factors into the analysis of the causes of the population's poor health, such as climate change, which in a few years will cause an additional 250,000 deaths each year. Improving global health inevitably involves looking at climate change and establishing a strong global commitment to implement coherent policies that influence healthy environments.

Humanitarian Action (HA), for its part, continues to drift in 2018, allocating just 1.9% of total ODA -some 51 million Euros- to help alleviate the humanitarian needs of over 135 million people affected by some type of crisis.

Finally, transparency and accountability are essential if development cooperation is to be brought closer to citizens. Initiatives are useless if they are not resourced and serve their purpose.

Health in the world

In the fourth year of Sustainable Development Goals (SDG) implementation, the United Nations (UN) warns of the urgent need to take action if we want to reach the agreed targets.

The main problems for its achievement are: lack of reliable and quality data; half-heartedness in the countries' response; absence of clear, consensus-based and evidence-based criteria on how to achieve them; increased global instability; and the questioning of some instruments needed to advance a common agenda.

To move forward on the 2030 Agenda, all countries need to address these commitments within a rights-based approach, where people and the planet take precedence over other interests and accelerate evidence-based action to achieve the agreed goals.

SUSTAINABLE DEVELOPMENT GOALS



Source: United Nations

Health inequity remains our greatest global health problem, and the most impoverished and vulnerable people continue to have poorer health.

Universal health coverage (UHC) is a chimera in many countries. However, we have sufficient technical knowledge to substantially improve, for example, maternal and neonatal health.

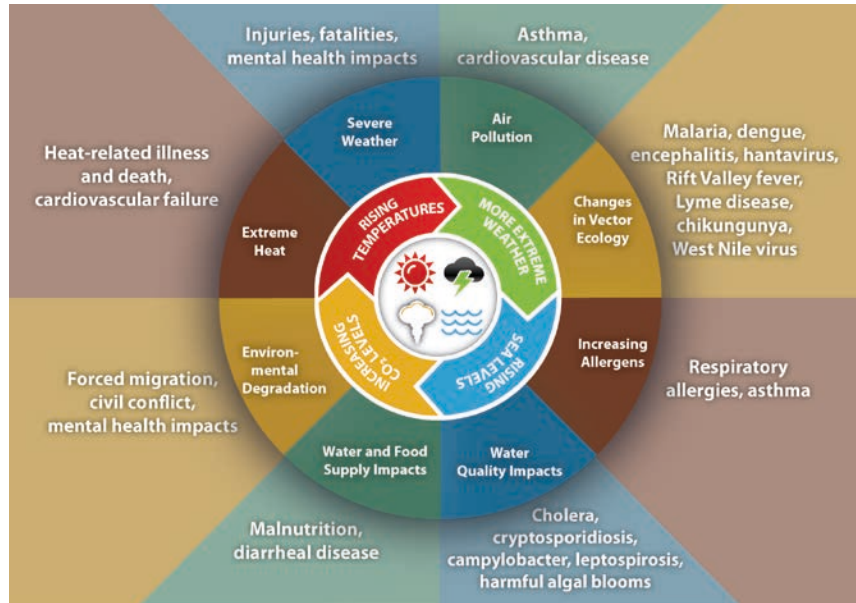
We need to ensure that health is addressed with a comprehensive approach, incorporating social determinants of health, strengthening public health systems and that universal health includes its commitment to a Right to Health that “leaves no one behind” and that is not subservient to commercial or political interests. In addition, we must work on the right to health in all policies, at local, national and global level.

New factors are incorporated into the analysis of the causes of the population's poor health such as climate change which, according to the World Health Organization (WHO), will cause between 2030 and 2050 an additional 250,000 deaths each year mainly due to increased malnutrition, malaria, diarrhoea and caloric stress.

Climate change is a factor that is hardly taken into account when analysing the causes of ill health. However, it influences the social and environmental determinants of health, such as clean air, clean water, sufficient food or safe housing. Its extreme impact has other important consequences on people's daily lives, such as overcrowding of health services, as extreme temperatures affect people with cardiovascular disease, diabetes or chronic diseases. In fact, known environmental problems cause 13 million deaths each year, especially among the most vulnerable.

Improving global health requires tackling climate change and establishing a strong global commitment to policy coherence that will lead to healthy environments. If this is not done, WHO should declare climate change a global public health emergency, bearing in mind that it affects a far greater number of people than some of the latest declared epidemics such as Ebola and Zika.

IMPACT OF CLIMATE CHANGE ON HUMAN HEALTH



Source: Centre for Disease Control, USA

In a hyper-connected world, health is greatly affected by fake news, which makes people take decisions that can negatively affect their health.

Opposition to vaccines is one of the issues that generate the most hoaxes and false truths. It is also worth recalling a certain weakness in the credibility of the health scientific paradigm, which has not done enough to prevent commercial interests from affecting decision-making based on false evidence, which is another form of fake health news. Medicalization of life, lack of transparency, a dubious relationship between a drug's research cost and its final price, or directly the dissemination of false studies biased by commercial interests, do nothing to increase the trust in scientific evidence.

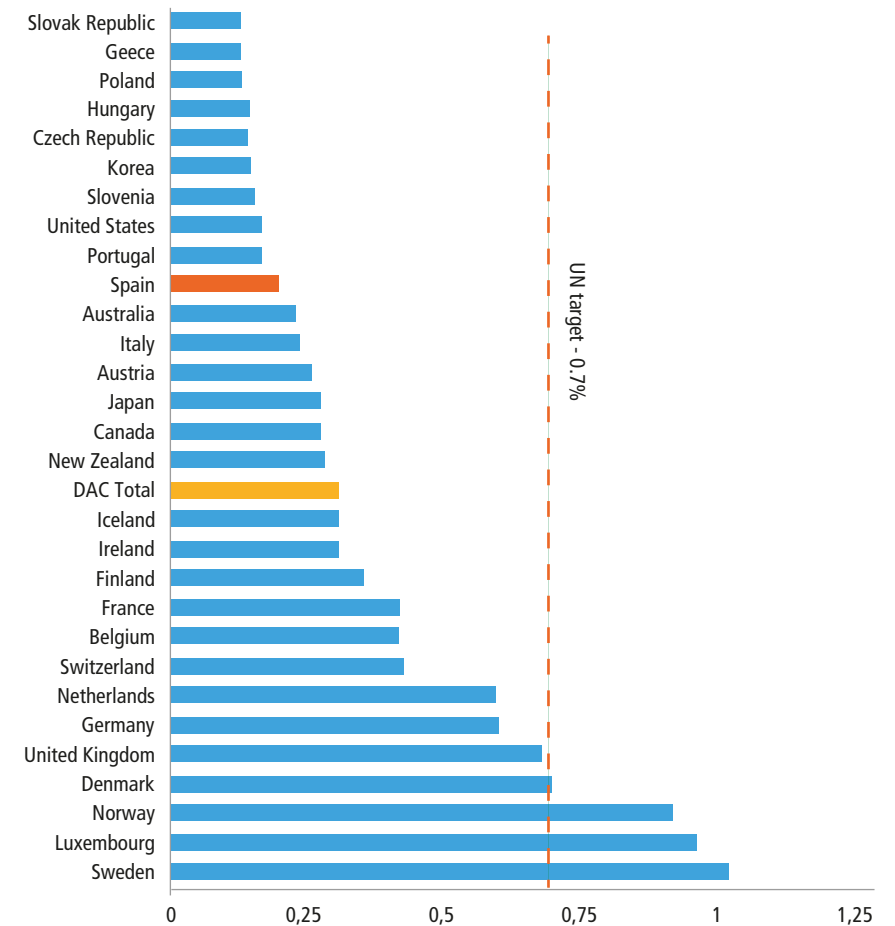
Our society has agreed to medicalize life, making health a breeding ground for all kinds of fake news. In order to combat this problem, alongside demanding scientific evidence, there is an urgent need to provide citizens with tools to identify fake news in health.

International perspective

In 2018, DAC countries' total ODA stands at 143,218 million Dollars, a fall of 2.7% (about four billion) compared to 2017.

This represents only 0.31% of Gross national income (GNI), well below the 0.7% -minimum- committed by donors at the UN Assembly.

DAC COUNTRIES' ODA AS PERCENTAGE OF GNI, 2018

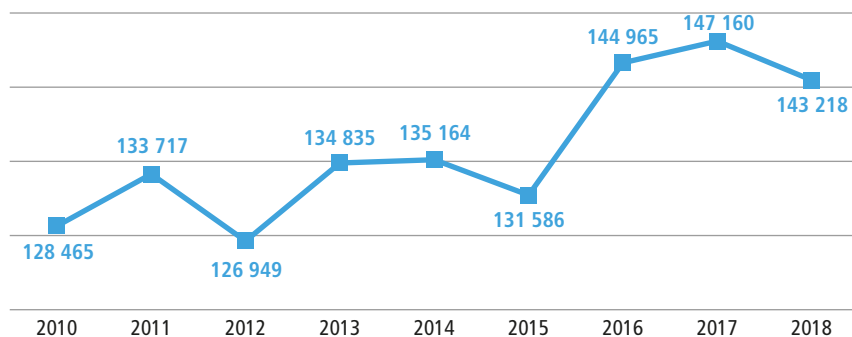


Source: OECD, 2018

Spain, on the other hand, repeats in 13th place with respect to absolute figures allocated to development cooperation, and is 20th out of 29 countries with respect to the percentage of GNI. After four years of implementing the 2030 Agenda, there are still no major changes that would allow us to think that DAC countries as a whole are going to fulfil their commitment to allocate 0.7% of their GNI to development cooperation in 2030.

All DAC countries need to make a real commitment to allocate 0.7% of their GNI to genuine ODA. This requires first a credible and public roadmap in which all countries establish a plan to reach the target. The example of the United Kingdom, which enshrined in law its commitment to spending 0.7% on aid annually, is a good way to fulfil that commitment, beyond countries' political ups and downs.

TRENDS IN NET ODA BY OCDE COUNTRIES (IN CURRENT MILLION DOLLARS)



Source: OECD, various reports

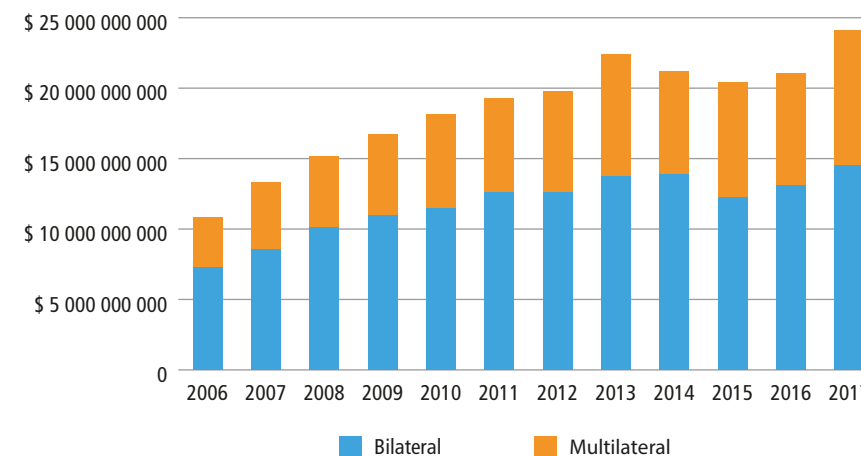
DAC's health ODA increased by 14.6% in 2017, reaching 24,091 million Dollars, which is equivalent to 13.8% of total aid, highlighting the importance of this sector for donors as a whole.

The above figures imply that in 2017 3,000 million Dollars more were allocated to health than in 2016. This increase has occurred in both bilateral and multilateral aid, although the latter has grown slightly more than bilateral aid. Although this indicates that, on average, the sector is an important one for donor countries, we must point out that the European institutions, which include the European Commission and the Secretariat of the European Council, barely allocate 5% to health.

At international level, health should be seen as a crosscutting policy issue, as it is a prerequisite, an outcome and an indicator of the three dimensions of sustainable development. All countries should adopt a multisectoral approach and act on the

social, environmental and economic determinants of health, with a view to reducing health inequalities and enabling a real sustainable development.

GROSS ODA DISBURSEMENT BY CAD COUNTRIES TO THE HEALTH SECTOR (SECTOR 120 AND 130) BY CHANNEL (IN CURRENT DOLLARS)



Source: Own elaboration from data published by OECD-CRS

The “Action Plan for the implementation of 2030 Agenda” sets out the challenge of moving towards a society with inclusive economic growth, greater social justice and cohesion, in peace and with a sustainable environmental horizon.

The SDGs are universal, apply equally to developed and developing countries, and address the root causes of poverty, inequality and the planet's degradation, with a transformative will. The “Action Plan for the implementation of 2030 Agenda” is considered a first step towards establishing a sustainable development strategy. Regarding health, it aims to mainstream the contents of the Agenda, integrating its three dimensions -social, environmental and economic-, and maintaining the universal, public and free character of the health system.

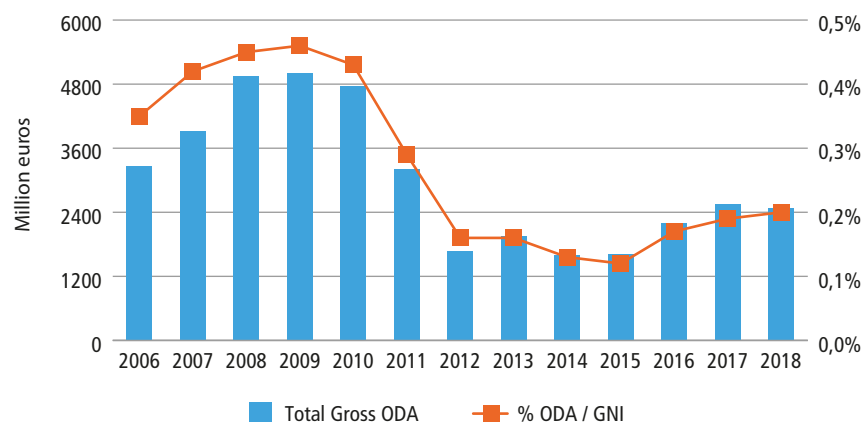
It is crucial an agreement among all political parties and authorities at all levels on what and how Spain wants to implement the SDGs. Otherwise, we run the risk of changes in the country's political direction or some public institution causing paralysis, even setbacks in achieving the SDGs. Society's participation must be real, as must the financing, otherwise it is impossible to fulfil the commitments made.

Health in Spanish cooperation

In 2018 Spanish ODA reaches 0.20% of GNI, a percentage insufficient to meet the 0.7% commitment, and very far from the 0.31% for all DAC donors and 0.47% for European Union countries.

Gross ODA disbursed by Spain in 2018 reached 2,483 million Euros, 3% less than in 2017. This figure does not correspond to the increase foreseen in the General State Budget Proposal for 2018 for the first year of the Fifth Master Plan, which was to reach 2,602 million Euros, 0.22% of Gross national income.

TREND IN GROSS ODA AND AS PERCENTAGE OF GNI, OVER 2006-2018



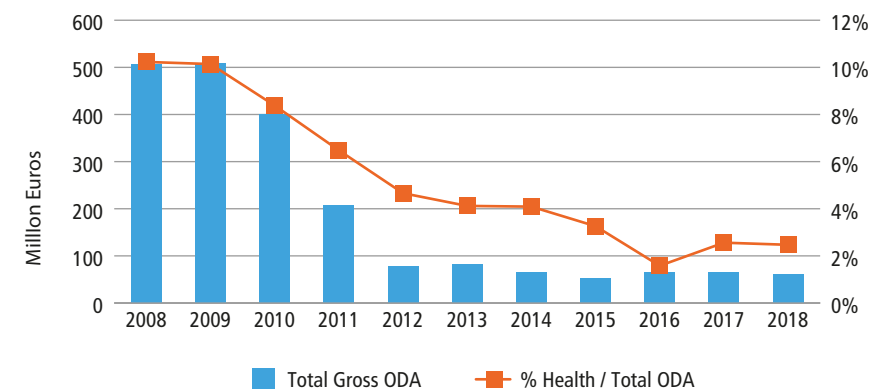
Source: Own elaboration from ODA data published by DGPOLDES

The weight of health in Spanish cooperation continues to fall and stands at 2.47% of total gross ODA, far below the 13.8% average for all donors.

In 2018, 61.3 million Euros were allocated to health, 6.4% less than in 2017, which means that health continues to lose weight within Spanish cooperation, and far from the figures and percentage allocated 10 years ago. If we deduct loan repayment, Spanish cooperation would only have allocated 20 million Euros to health in 2018, which represents 67.3% of the total amount allocated to health in that year.

Spain should increase its health ODA and its weight in total Spanish ODA to reach the donors' average if Spain wants to have a greater role in the international sphere. If the government incorporates health as a universal right, both internally within the State and globally, this would help prioritise health over other policies.

TREND IN HEALTH GROSS ODA AND AS PERCENTAGE OF TOTAL ODA, 2008-2018



Source: Own elaboration from ODA data published by DGPOLDES

Decentralised cooperation represents 43% of total Spanish health ODA. However, it continues to be a very heterogeneous aid with a great deal of variability from one year to the next, which prevents it from being more efficient and having a greater impact.

Health cooperation of both, Autonomous Communities (CCAA) and Local Bodies (EELL), reached 26.4 million Euros, 5.2 million more than in 2017, doubling the increase in decentralised ODA. This amount represents 10.67% of total decentralised aid, a percentage closer to the 13.8% allocated by DAC donors and far higher than that allocated by state cooperation. However, there is still a very uneven behaviour between the different actors and even between the same actors, which makes it difficult to predict their aid, its effectiveness and impact.

Decentralised cooperation, both autonomous and local, is and must continue to be a benchmark in Spanish health cooperation. It is necessary to increase its participation in the definition of priorities. But there must be a political commitment, accompanied by a consistent growth in budget allocation and quality.

TOTAL DECENTRALISED HEALTH ODA, 2016-2018

CCAA+EELL	Health ODA 2016	Health ODA 2017	Health ODA 2018
Andalucía	6.051.595 €	2.895.000 €	1.098.153 €
Aragón	1.182.399 €	540.910 €	911.630 €
Asturias	766.564 €	649.761 €	67.743 €
Baleares	204.461 €	704.091 €	612.093 €
Cantabria	49.810 €	60.000 €	320.639 €
Canarias	175.830 €		439.520 €
Cataluña	3.326.891 €	5.363.773 €	9.576.623 €
País Vasco	2.873.345 €	3.358.706 €	2.499.596 €
Castilla-La Mancha	705.994 €	401.953 €	377.632 €
Castilla y León	883.819 €	536.112 €	783.637 €
Extremadura	1.474.964 €	1.891.586 €	1.266.381 €
Galicia	781.194 €	503.458 €	732.712 €
La Rioja	156.310 €	177.201 €	174.624 €
Madrid	164.642 €	565.243 €	1.027.047 €
Murcia	14.100 €	122.361 €	87.632 €
Navarra	2.293.702 €	2.175.552 €	2.684.548 €
C. Valenciana	1.132.808 €	1.188.569 €	3.750.008 €
Ceuta			
TOTAL	22.238.428 €	21.134.276 €	26.410.219 €

Source: Own elaboration from the ODA PACI reports and data published by DGPOLDES-SECIPIC

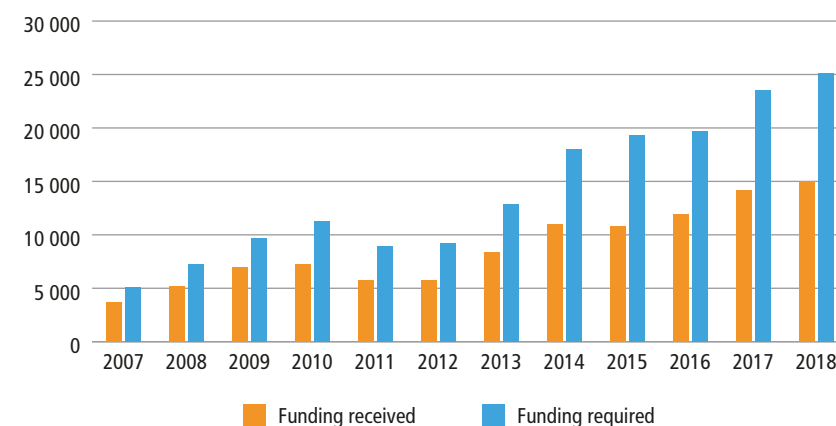
Humanitarian action

The funding gap for International Humanitarian Action (IHA) remains at 60%, while the international community remains unable to respond adequately to growing humanitarian needs.

In 2018, international humanitarian action amounted to 28.9 billion Dollars. While this is a slight increase from 2017, it barely covers 60% of humanitarian needs. In addition, the number and severity of humanitarian crises is likely to increase as a result of climate crisis, which may lead to increased conflict, displacement and increased risk of epidemics and heat waves. This increase in humanitarian crisis will require a greater response from the international community in terms of humanitarian response and vulnerability reduction, improved warning systems and strengthened response capacities. Responding adequately to this challenge requires real political will and financing that is robust and sustained over time.

Donors must therefore assume their international responsibilities and commitments, such as allocating at least 7% of ODA to HA and substantially increasing funding for HA.

UN FUNDING APPEALS 2008-2018



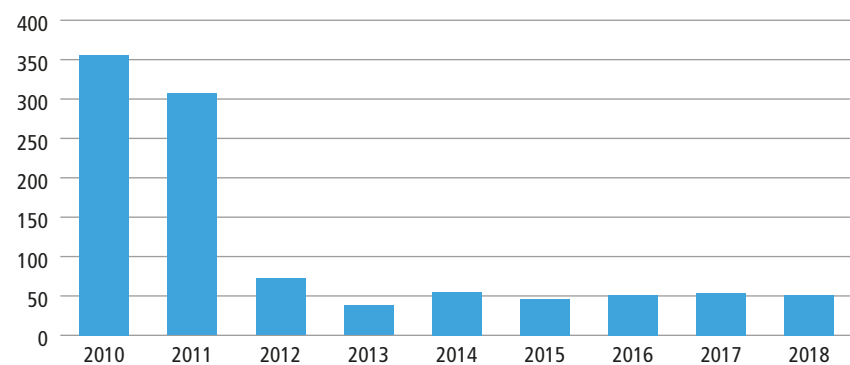
Source: Own elaboration from UNOCHA's FTS data

Spanish cooperation's Humanitarian Action (HA) continues to drift, with further cuts that place it at the level of 2016. If 54.4 million Euros were allocated in 2017, in 2018 it has barely reached 51.7 million Euros.

In 2018, Humanitarian action as a whole (General State Administration -AGE-, CCAA, EELL and Universities) has experienced a decline compared to 2017. In addition, in 2018 the HA represented 1.9% of total ODA, which places it at an all-time low. This takes us further away from the commitment to allocate at least 10% of ODA, included in the new Humanitarian Action Strategy of Spanish Cooperation 2019-2026.

Given the weakness of HA in Spanish cooperation, and the systematic non-compliance with the 10% commitment, Spanish cooperation must establish a concrete and credible timetable to reach the objective of allocating 10% of ODA to HA in 2022.

TREND IN SPANISH ODA TO HUMANITARIAN ACTION



Source: Own elaboration from ODA data published by DGPOLDES

Decentralised cooperation's HA suffers further cuts, bringing it below 4% for the first time.

The funds earmarked for HA by decentralised cooperation (CCAA, EELL and Universities) fell by 10% in 2018, from 11.7 million Euros to 9.7 million Euros. There has been an almost generalized fall by Autonomous communities, as 13 out of 17 reduced their funding. This funding instability makes it impossible to respond adequately to increasingly complex and prolonged crises, which require medium-term support, which can only be achieved through stable and multiannual funding.

Decentralised cooperation must increase funding for HA and commit to the HA Strategy's objective of allocating 10% in 2022 to regain its role as a major player in HA.

DECENTRALISED HUMANITARIAN ACTION 2017-2018

CCAA+EELL	2017	2018
Andalucía	995.885 €	635.000 €
Aragón	269.799 €	371.954 €
Asturias	175.000 €	
Baleares	376.483 €	623.381 €
Cantabria	55.000 €	50.000 €
Canarias	30.000 €	24.000 €
Cataluña	418.541 €	822.070 €
País Vasco	3.507.758 €	2.986.589 €
Castilla-La Mancha	196.720 €	204.400 €
Castilla y León	158.798 €	144.077 €
Extremadura	862.811 €	500.500 €
Galicia	522.414 €	254.915 €
La Rioja	211.189 €	130.000 €
Madrid	2.677.397 €	442.999 €
Murcia	64.100 €	98.500 €
Navarra	620.750 €	517.500 €
Comunidad Valenciana	523.123 €	1.868.146 €
TOTAL	11.665.768 €	9.674.031 €

Source: Own elaboration from the ODA data published by DGPOLDES-SECIPIC



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