Chapter 20

Can International Aid Improve Health?

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Abstract

Can international aid improve global health? Many current health indicators suggest that millions of the poor suffer from a lack of basic healthcare. International aid to the health sector has increased fourfold over the last 40 years. However, macro-level cross-country studies argue that health aid is ineffective at improving mortality rates, life expectancy, and a number of other health indicators. Recent micro-level studies have found some evidence of successful health aid interventions. This chapter presents an overview of the current state of health in poor countries and summarizes the findings and conclusions from pre-existing work on health aid. We also explain, using the economic way of thinking, why health aid has not achieved results on a large scale. This relies on analyzing the role of information and incentives in both the donor and recipient countries.

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Key Points

- Health aid is increasing over time, while worldwide health trends are also improving.
- Macro-level evidence suggests that aid is ineffective at improving health, but micro-level analysis indicates some success stories.
- To explain this apparent paradox and why health interventions have not achieved widescale success, we utilize the economic way of thinking.
- Perverse incentives and a lack of information on the part of both donors and recipients helps to explain why health aid cannot improve health in a systematic manner.
- The ultimate policy (or group of policies) to improve health relies on achieving sustained economic growth, which increases the availability of quality healthcare for larger numbers of people.

Key Policy Implications

- With any foreign intervention, we must consider the local, pre-existing arrangements and institutions.
- Even if we find a solution that works at a local level, this does not mean that this policy is scalable and will work at the national level or in other countries or contexts.
- Ultimately, policies that support sustainable economic growth is the only way to achieve long-term, systematic improvements in healthcare and global poverty.

Introduction

Can international aid improve global health?[1] Attempting to answer this question is of critical importance as current heath indicators suggest that millions are still without basic care. For example, recent annual data suggest the following:

- About 7.6 million children died in 2010, with 1.7 million dying from vaccine-preventable diseases.
- Approximately 1000 women suffer from pregnancy-related deaths on a daily basis.
- One out of every five children is estimated to be underweight.
- There are approximately 2.6 million new HIV infections yearly, and 8.8 million new tuberculosis cases.[2]

The international aid community has increasingly given more attention to social matters such as health and education since the early 1990s. For example, as shown in Figure 20.1a, aid targeted to the social sector (which includes spending on health) continues to receive a larger share of total allocation compared with the other sectors.[3] Among the different social sectors, as shown in Figure 20.1b, health aid has received a large share of social aid over the past 20 years. Health aid includes assistance to hospitals and clinics, disease and epidemic control, maternal and child care, dental services, services for tuberculosis, vaccination programs, nursing, provision of drugs, public health administration, medical insurance programs, and reproductive health and family planning (OECD-DAC 2012).

These trends make sense given that most of the Millennium Development Goals (MDGs) – the blueprint for donors to meet the needs of the poor – target social outcomes. Specifically, three of the eight MDGs focus on global health outcomes (reducing child mortality, increasing maternal health, and combating HIV/AIDS, malaria and other diseases) with nine of the 21 targets aimed at health-related matters. The international donors support these stated goals as aid specific to the health sector continues to rise over time, in absolute terms and as a share of total aid (Figure 20.2). In 2010 alone, health aid accounted for 6% of total aid and amounted to approximately US$10 billion – four times the amount provided in 1994 (OECD-DAC 2012). From 1971 to 2010, aid has supported over 67,000 different health-related interventions at the project level, with approximately 50,000 of those projects starting since 2000 (Findley *et al.* 2009).

Before examining the pros and cons of international aid for global health, it will be useful to provide a quick overview of the current status of the foreign aid debate as some of the main tenants in this debate still hold for health aid.

Theory and empirical evidence debate the effectiveness of foreign aid to achieve economic development. Two main camps have emerged: the "public interest" view versus the "public choice" view (Williamson 2008).[4] The public interest view claims that foreign aid can be useful because it can break countries out of a so-called "poverty trap." The most notable economist in the public interest camp is Jeffrey Sachs. Sachs' story (see, for example, *The End of Poverty*, 2005) is that poor countries are often tropical, landlocked, malaria infested, and barren, making investment targeted toward economic development extremely difficult. Since poor countries cannot afford these investments, they are poor simply because, well, they are poor, resulting in a vicious circle of poverty. Sachs proposes a solution to this perplexing dilemma by arguing that foreign aid can jump-start a country onto a new path – a virtuous circle where countries receive the necessary initial investment in critical areas to make them productive by allowing them to break out of

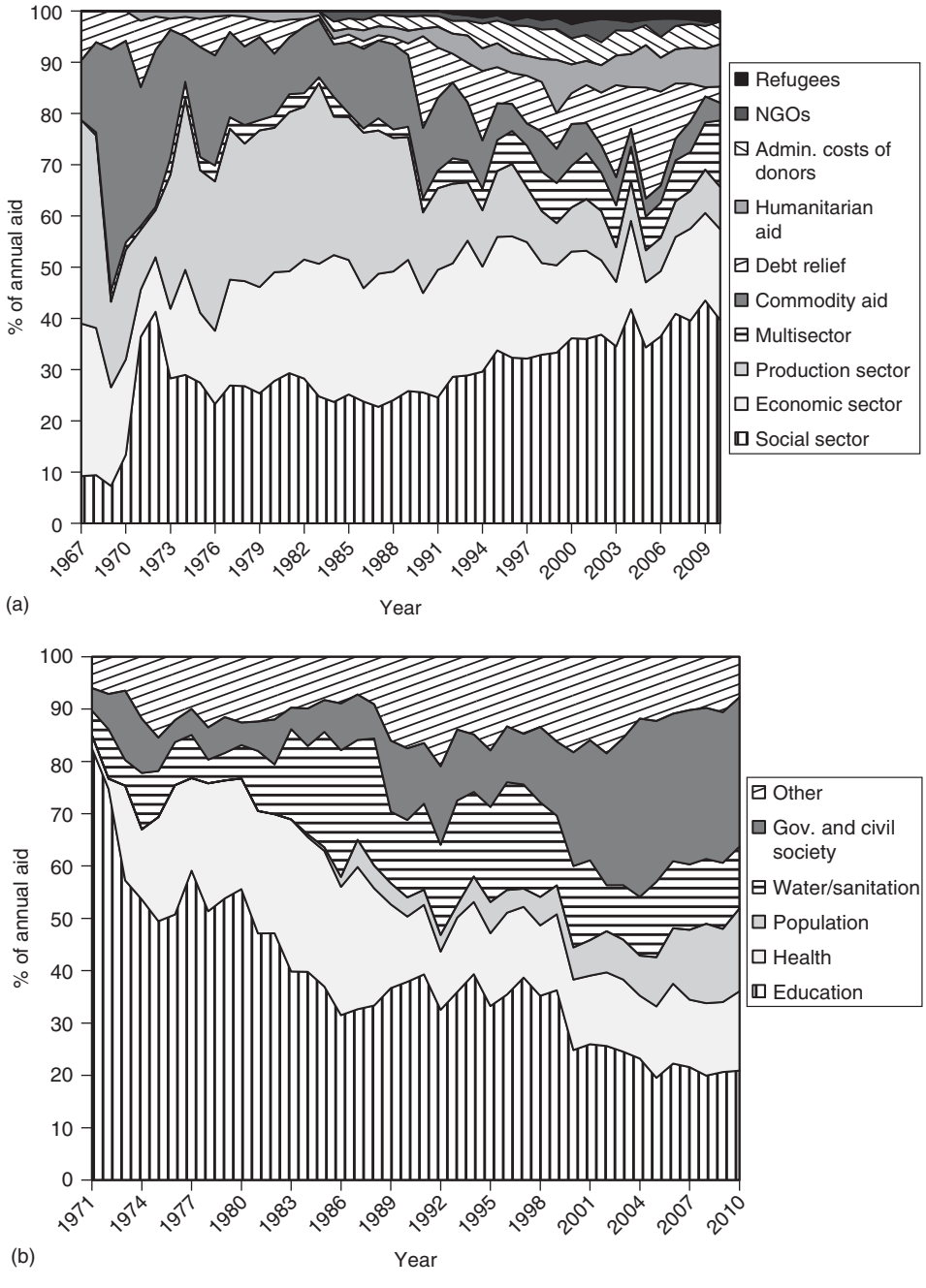

Figure 20.1 (a) Sectoral trends and (b) sectoral social sector trends in the allocation of annual world aid, 1967–2010. Source: data from OECD-DAC Reporting System (2012), International Development Statistics.

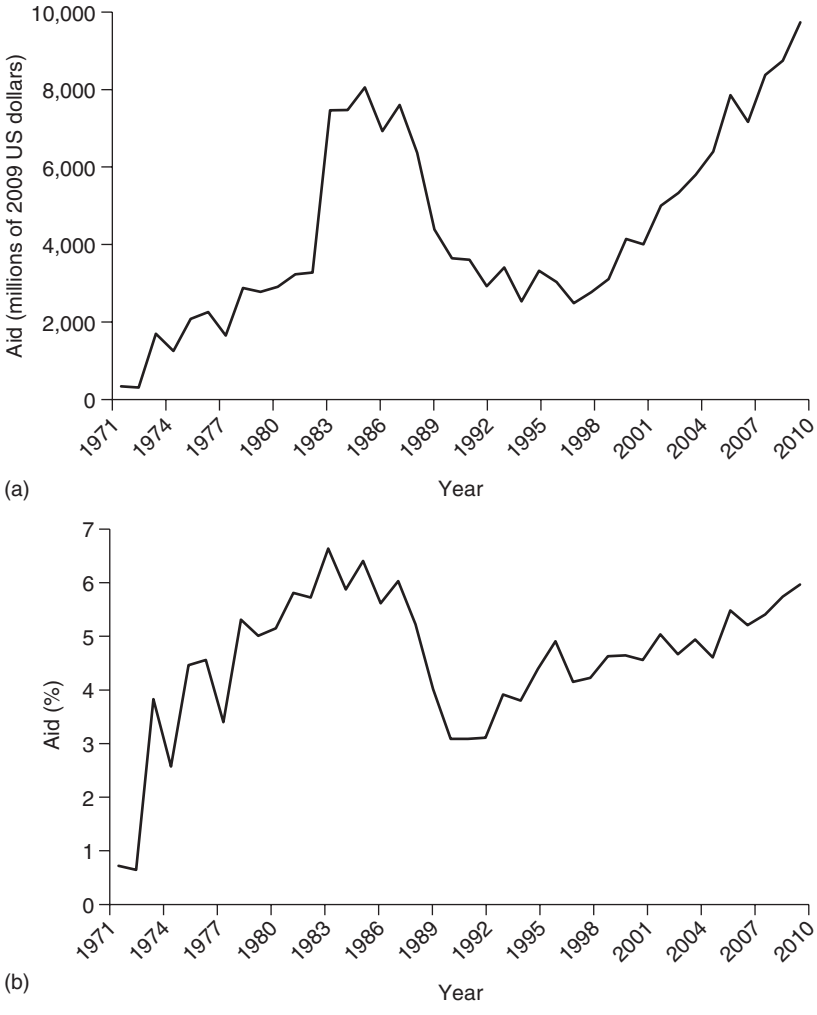

Figure 20.2 (a) Total health aid and (b) health aid share of total aid budget, 1971–2010. Source: data from OECD-DAC Reporting System (2012), International Development Statistics.

the poverty trap. This initial increase in productivity will result in individuals generating enough subsequent income so they themselves can save, leading to future benefits. Sachs calculates the exact amount of foreign aid needed to end poverty by 2025 as being $195 billion per year from 2005 to 2025.

Also supporting the notion that aid should, and can, be used to end poverty are Peter Singer (1972) and Amartya Sen (1999). Part of their arguments hinge on a moral presupposition that we have a duty to help those less well off. Specifically, they argue that poverty handicaps individuals from realizing their full potential. Being poor is not just a lack of money but also a lack a capacity to pursue a flourishing and meaningful life. Sen refers to health as one of the building blocks of development and argues that improvements in health facilities and institutions are fundamental in this process. He stresses that being rich is not a prerequisite for healthcare because even in relatively wealthy societies there can be some individuals who lack the healthcare necessary to pursue a meaningful life.

In contrast to the public interest view, the public choice view holds that foreign assistance goes to governments who may or may not have the public interest in mind. Instead of assuming that the political elite are altruistic and other-regarding in their motives, the public choice approach begins with the assumption that politicians, like those in the private sector, pursue their own interests, which may be narrowly self-interested or broader and other-regarding. Peter Bauer (2000), a proponent of the public choice view, highlights how foreign aid is neither necessary nor sufficient for economic development. In fact, he argues that foreign aid may actually impede growth because it alters incentives in an unfavorable manner (discussed in detail in subsequent sections). Bauer notes that the money intended to help those in need often ends up in the hands of the political elite who may support bad policies and reinforce the predatory policies that are a contributing factor to the existing state of affairs. According to Bauer, the mere existence of developed countries defies the poverty trap argument for foreign aid. After all, at one point all countries were poor, meaning that there was no wealthy country to provide foreign assistance to the first countries that rose from poverty to prosperity. This realization stands in contrast to the standard claim that countries need foreign assistance in order to break out of a vicious circle in order to grow into a virtuous one.

William Easterly (2001, 2006), another proponent of the public choice view, also discusses how foreign aid does not promote growth. He debunks the argument that foreign aid is necessary to make up for the lack of investment in developing countries. Aid, by itself, will not change the incentives to invest in the future and can actually create dependencies that discourage such investments. In addition to highlighting a variety of perverse incentives created by foreign aid, Easterly also discusses how there is a lack of knowledge with the current top-down foreign aid approach, which is similar to Soviet-style central planning. Development is not an engineering or technological problem; instead, it requires constant trial and error and continual searching. Donors rely on the bureaucratic process to try and solve these knowledge problems, a process that often fails to deliver the necessary feedback and monitoring. This is precisely why Easterly emphasizes the importance of "Searchers" over "Planners," since the former refer to those engaged in the process of discovery and experimentation. A large and robust empirical body of work backs up the public choice perspective (Boone 1996; Svensson 1999, 2000; Knack 2001; Brumm 2003; Ovaska 2003; Djankov *et al.* 2006; Powell and Ryan 2006).

Perhaps the aid debate has focused for too long on the big questions such as how to end world poverty. Instead, some aid proponents (for example, Banerjee and Duflo 2011) argue that the discussion should shift toward piecemeal, well-targeted outcomes such as increased vaccinations or providing bed nets. This approach draws a distinction between aid for growth and aid for health. While development is not a purely technological problem, many health-related issues are. We may not know how to solve world poverty, but many global health issues such as preventing certain diseases, preventing deaths related to diarrhea, providing birth control, and treatment for malaria and tuberculosis *are* technical, logistical exercises in moving resources from point A to point B. And many of these solutions have been known for decades. Therefore, health aid should be the "easy" case for aid since health-related issues are concrete problems and the solutions to these problems are (mostly) known.

In this context, a recent article by Skarbek and Leeson (2009) is relevant, where the authors argue that aid can be seen as both as a success and a failure: "Aid can, and in a few cases has, increased a particular output by devoting more resources to its production. In this sense, aid has occasionally had limited success. However, aid cannot, and has not, contributed to the solution of economic problems and therefore economic growth. In this much more important sense, aid has failed" (Skarbek and Leeson 2009: 392). They

go on to argue that, at its best, aid can provide more goods and services, but still not find the solutions to the economic problem of poverty. "So, what can aid do? Like other forms of central planning, aid can increase X by devoting additional resources to X's production … If planners pick a specific outcome, such as more immunizations, aid can provide additional resources to produce immunizations. All of the 'success stories' that aid's advocates highlight are of this nature" (Skarbek and Leeson 2009: 394).

This argument implies that even if aid cannot increase growth and end world poverty, it may be able to ease human suffering *in the mean time*. Although, the best way to alleviate poverty is for a country to achieve sustained economic growth, the question is can aid decrease human suffering while we wait for growth? Until poor countries begin to experience the benefits from more development, health aid may be able to alleviate some of the consequences of extreme poverty. Even in countries that are experiencing high growth rates and increases in standards of living, Boone and Johnson (2009) argue that pockets of poverty still may persist. In principle, health aid may be able to intervene to provide basic care and eliminate the cruelest of suffering for countries stuck in poverty traps and individuals still living in pockets of poverty.

In what follows, we consider the evidence regarding global healthcare outcomes and how these outcomes relate to increased spending on health assistance. We then turn to the economic way of thinking to explain why efforts to provide health assistance to those in need often fail. We conclude with the policy implications of our analysis.

Examining the Evidence

Worldwide trends related to health are improving. For example, Figures 20.3–20.5 illustrate that both the overall death rate and infant mortality are on the decline and life expectancy is increasing. This holds for all income groups.[5]

As stated earlier, health aid is increasing over time as health indicators are improving. Are the two related? Has health aid actually made a difference? Once again it depends on what is described as the end goal. Aggregate studies indicate that health-related aid

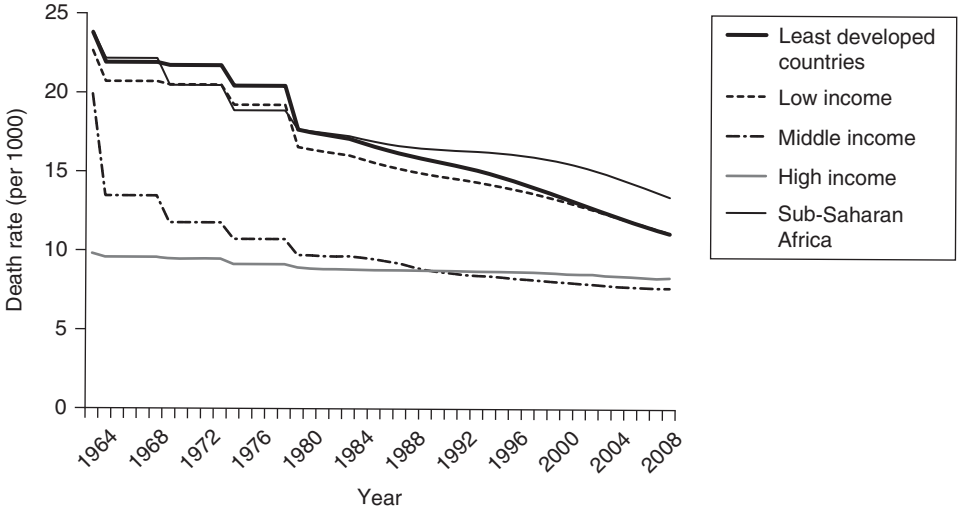

Figure 20.3 Death rate per 1000 population, 1964–2009 (5-year moving average). Source: data from World Bank (2011), World Development Indicators.

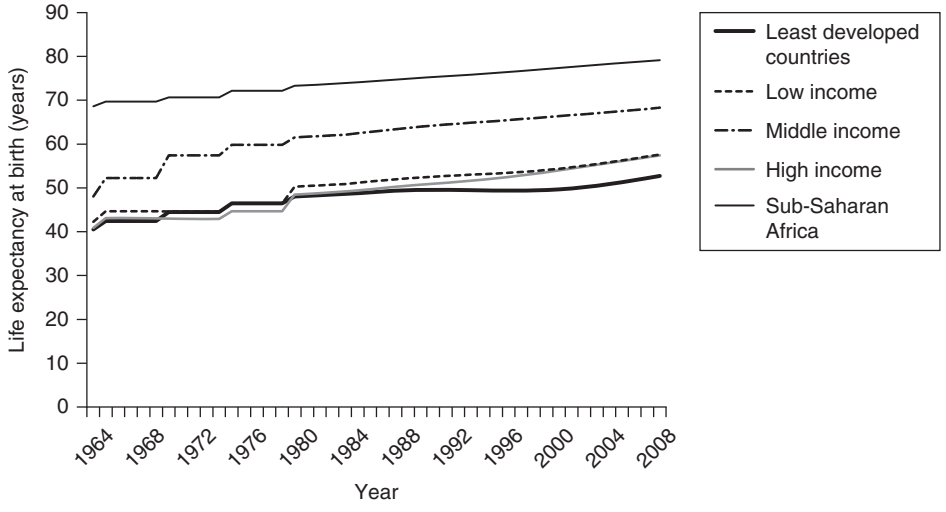

Figure 20.4 Life expectancy at birth in total years, 1964–2009 (5-year moving average). Source: data from World Bank (2011), World Development Indicators.

has no impact on health outcomes. On the contrary, there are micro-level data showing that aid is (somewhat) successful at building hospitals, providing vaccines, and bed nets, for example. We consider each in more detail.

Williamson (2008) examines aid earmarked specifically for the health sector to determine its effect on infant mortality, life expectancy, death rates, and immunizations (diphtheria, pertussis, and tetanus (DPT) and measles). The analysis shows that aid has not had any effect on the five dimensions of health studied. The results support the public choice perspective discussed above, indicating that international aid to the health sector

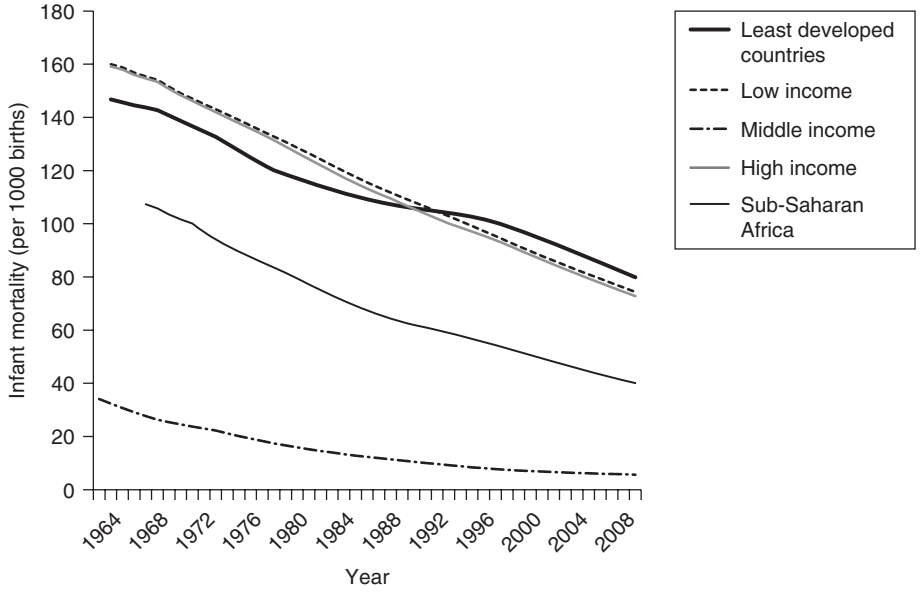

Figure 20.5 Infant mortality per 1000 births, 1964–2010 (5-year moving average). Source: data from World Bank (2011), World Development Indicators.

may be an ineffective policy tool for improving human welfare. In this sense, health is not "special" relative to other forms of development assistance. Just like general aid, which is shown to have an insignificant effect on economic development, aid used specifically for health goals has an insignificant effect on human development.

A follow-up study by Wilson (2011) also finds support for Williamson's conclusion. Wilson uses a new data source, AidData, compiled by Findley *et al.* (2009), to show that development assistance for health does not reduce mortality at the country level. However, economic growth does have a strong negative effect on mortality (as we would suspect). His analysis also supports the notion that health aid effectiveness has not increased over time even though the amount of health aid has increased fourfold. Wilson summarizes his finding as "development assistance for health appears to be *following* success, rather than *causing* it" (Wilson 2011: 2031, italics in original). In other words, economic growth precedes improved health outcomes.

Even though health aid has no discernable effect on county-level aggregate indicators, there are public health programs and projects that might show positive results for specific health outcomes. This is exactly what researchers engaged in randomized controlled trials (RCTs) are attempting to discover. They want to shift the focus away from the "big questions" of what ends poverty towards more narrow ones, such as how to immunize children and increase bed net usage in specific, local contexts.

In *Poor Economics: A Radical Rethinking of the Way to Fight Global Poverty*, Banerjee and Duflo (2011) summarize the last 15 years of research, including hundreds of RCTs, on trying to understand solutions to global poverty. They call health one of the greatest areas of hope but also of great frustration as the solutions to many health-related problems are "low-hanging fruit." However, many of these fruits are left unpicked. Why? As one example illustrates, getting individuals in poor countries to understand "miracle drugs" such as oral rehydration solution (ORS) or chlorine bleach is harder than previously thought: in one Indian town many children die from diarrhea, but ORS, an extremely cheap solution, has not been that effective at saving lives. The reason is that many mothers do not believe that ORS does any good, resulting in the lack of adoption of a solution that is known to be effective.

Banerjee and Duflo summarize this experience, and many others similar to it, as a lack of information and weak beliefs on the part of those suffering from poor health and poverty. The poor often spend valuable resources on healthcare but on the "wrong" healthcare, demanding unnecessary antibiotics or surgeries that come too late to be effective. The poor also tend to believe that the public health system does not work, preferring to use private providers or traditional healers.

This sentiment is also echoed in Samia Waheed Altaf's (2011) book, *So Much Aid, So Little Development: Stories from Pakistan*. Altaf was hired as a technical assistant in the 1990s to the Social Action Program (SAP) in Pakistan. Her journey illuminates how aid actually works and why it fails. She explains that her "own understanding of this situation is that program designs are based on limited conceptual frameworks that reflect a woefully inadequate knowledge of local realities, and thus are inappropriate in the context of national constraints" (Altaf 2011: 3).

Taken together, both the macro- and micro-level studies suggest that even though there are known and cheap cures to many of the health-related issues of the poor, implementing policy that *delivers* effective healthcare has proved to be daunting in practice. The following sections draw on the economic approach to provide insight into the disconnect between the knowledge possessed by those in developed countries regarding healthcare and the effective delivery of these services to those in need.

The Economic Way of Thinking

The puzzle we need to explain is why health-related foreign aid has failed to positively impact health outcomes. Conceptually, the task at hand is clear – donors need to identify those in need of healthcare and then deliver the appropriate assistance. What then explains the failure of health-related aid to improve health outcomes? The economic way of thinking provides insight into this puzzle.

An economic approach is grounded in a few basic, related assumptions. One is that people have ends that they seek to pursue. This just means that each person has certain goals they wish to accomplish. Second, economists assume that people are rational. This does not imply that people are infallible automatons, but rather that they pursue their ends the best way known to them at the time of action. Finally, people respond to incentives, meaning they respond to changes in costs and benefits associated with a course of action.

In addition to these core assumptions, the central economic question is how decisions are to be made regarding the use of scarce resources. Scarcity necessitates choice which, in turn, implies trade-offs since one feasible use of scarce resources must ultimately be chosen over another potential use. The answers to these questions, which constitute the "economic problem," are not given and instead must be discovered in all contexts where scarcity exists, no matter what the desired end – purely humanitarian concerns, maximizing monetary profit, or some other end.

These assumptions and the core economic problem bring into focus the two central issues related to our puzzle regarding health aid and health outcomes. First, the success of health-related aid depends on the existence of the appropriate incentives in the donor and recipient countries. In other words, donors must have an incentive to deliver aid to those most in need, and recipients must have an incentive to use the aid in the matter desired by the donors. Second, both donors and recipients must possess, or obtain, the necessary information to solve the economic problem. Taken together, the incentive and information issues result in a "double-edged sword," which explains why foreign aid is often ineffective (Williamson 2010). If donors and/or recipients lack the appropriate incentives and information, then assistance will fail to have the desired outcome. This applies to health-related assistance just as it applies to foreign aid more broadly. The next two sections explore the role of incentives and information in more detail.

Incentives

As per the public interest view, discussions of foreign aid often implicitly assume benevolence on the part of donor and recipient governments. It is assumed that those involved in delivering health-related aid to those in need put aside their own interests and agendas in order to altruistically assist those in need. This implies that the various parties involved in dispersing and receiving aid utilize the most effective means to achieve the ends of improving health-related outcomes. It is taken for granted that donors are unbiased in their initial decision to donate to certain countries and that recipient government allocate health-related assistance in a manner that accomplishes the desired goals. The public choice view calls this assumption, and the related implications, into question.

The subfield of public choice economics applies the economic way of thinking to non-market decision-making. This includes the entire foreign aid enterprise, which takes place outside the market context. Public choice calls for an extension of the core assumptions laid out previously to both market and non-market decision-making. Often, people have

little difficulty applying core economic assumptions to market-related activities, but they assume that people transcend these economics in non-market-related behavior. Public choice economics indicates that this way of thinking is incomplete because people are not transformed from narrowly self-interested individuals into benevolent and other-regarding angels when they move from market to non-market-related activities.

This implies that instead of assuming benevolence on the part of those involved in allocating and distributing health aid, we instead need to focus on the incentives created by the institutions within which these individuals act. Public choice indicates that even though the provision of health-related aid may be motivated by the best of intentions, there are incentives at work which may prevent those desired ends from being achieved. For example, interest groups will seek to influence the actions of both donor and recipient governments to support their agenda even if it is at odds with providing health-related aid to those most in need. Meanwhile, bureaucrats in positions to disperse aid will attempt to influence the process by maximizing their budgets and attempting to create a demand for their services. Finally, elected officials in both donor and recipient countries will seek to pursue their own agendas in the disbursement and allocation of foreign aid. The interaction of these various forces will influence how much health-related aid is disbursed, as well as where and how the aid is allocated. The main result from the public choice model applied to health-related aid is that those involved in the process may fail to facilitate the coordination and cooperation that is necessary to transform spending on healthcare into improved health outcomes.

Donor Incentives

Donor countries and aid agencies face specific incentives when developing policies related to health-related assistance. These incentives emerge from the institutional structures – democratic politics, non-profit government bureaucracy, etc. – within which the pertinent parties act. This subsection explores how the incentives faced by the relevant players – elected officials, special interests, and bureaucrats – shape the effectiveness of health-related aid.

In principle, elected officials within donor governments would cater to the wants of voters. However, a key insight from public choice economics is that individual voters do not have the incentive to become informed about foreign aid policy, let alone the smaller portion dedicated to healthcare, and therefore remain "rationally ignorant" of the specifics of policy. The implication is that in reality individual voters exert little control over health aid. In stark contrast to individual voters, special interest groups within the donor countries do have the incentive to become informed in order to secure large benefits for their members, even if these benefits do not maximize the benefits to those in need in other countries. This logic implies that we should not expect politicians in donor countries to form health-related aid policies that will maximize the value of scarce resources dedicated to improving healthcare from the standpoint of the ultimate consumers – those in need. Instead, domestic political pressures, including lobbying interests, determine policies.

As an example of how domestic politics influences health-related assistance, consider the case of condom production for HIV/AIDS and family planning programs (Dugger 2006). The US Agency for International Development (USAID) has restricted contracts for condom production to US companies, currently manufacturers in Alabama. USAID could buy condoms from Asian manufacturers for half the price, but Alabama Senator Jeff Sessions has continually pushed to ensure that USAID buy condoms from producers

in his state. Ultimately, this means that USAID could purchase twice as many condoms – one of the most effective means of slowing the transmission of HIV/AIDS – if domestic special interests did not have to be considered. Domestic producers benefit from producing condoms and elected officials respond to these incentives even though they could increase the number of condoms and potential health-related benefits.

What this example illustrates is that assistance is given based on who wins the political competition through which aid decisions are made. Indeed, an existing literature indicates that donors disburse foreign aid based on political motivation and not necessarily based on the need of the final recipients (see Mosley 1985a, 1985b; Trumbull and Wall 1994). Further, Boone (1996) shows that aid reflects the relatively permanent strategic interests of donors. Taken together, this literature helps to explain why increased spending on health-related assistance does not necessarily result in improved healthcare outcomes.

In addition to special interests, the incentives facing bureaucrats also play a role in influencing health-related aid policy. For example, bureaucrats operate in an environment of negligible feedback from beneficiaries, hard-to-observe outcomes, and low probability that bureaucratic effort will actually translate into favorable outcomes. In response to these incentives, aid bureaucracies have organized themselves "as a cartel of good intentions, suppressing critical feedback and learning from the past, suppressing competitive pressure to deliver results, and suppressing identification of the best channel of resources for different objectives" (Easterly 2002: 247). Numerous layers of bureaucracy are involved in the delivery of assistance. This results in weak incentives for accountability, as there are typically unclear lines of responsibility and ownership over the use of health-related aid. When aid-related projects and initiatives fail, it is rare for a single agency, or a specific bureaucrat within an agency, to be held responsible for failing to achieve the stated outcome.

Bureaucrats in both governments and aid agencies face their own incentives. For example, donors, especially aid agencies, prefer to focus on aid disbursements (i.e., their "burn rate") as the preferred measure of success. Not only are disbursements observable but they are also the agency's budget, and an agency's budget is its source of existence. Without profit and loss, bureaucrats measure success by the size of their discretionary budget, which creates perverse incentives for spending money even if saving for future periods was the preferable course of action. Indeed, bureaucrats face the incentive not only to exhaust their current budget, but also to ask for increases in their annual budget in order to increase the size of the agency. Given these incentives, there is no reason to assume that bureaucrats in donor governments and aid agencies will choose to pursue the most efficient policies and strategies related to improving health outcomes.

We should also note that similar logic applies to non-governmental organizations (NGOs). Werker and Ahmed (2008) provide evidence that NGOs suffer from weaknesses, including inefficient, multilayer decision-making, low-quality service due to a lack of feedback, and agenda control stemming from pressure from national governments, their largest donors. NGOs do not transcend the logic of economics and the importance of incentives in the delivery of health-related assistance.

Recipient Incentives

Recipients refer to those who receive aid from donor governments. This includes the receiving government, individual citizens, and special interest groups within these countries. Recipients of aid face their own incentive structures. Foreign aid disbursements

tend to pass through the ruling governments in aid-receiving countries. From an economic standpoint, the central question is: what incentive do these governments have to actually achieve the desired health-related results?

Dysfunctional governments, which are unable to provide healthcare for their citizens, are a key reason that health-related foreign aid is needed in the first place. Corruption poses a major problem for foreign assistance in general because corrupt governments are unlikely to deliver aid in the intended manner. Under this scenario, recipient governments have little to no incentive to achieve the results desired by donors, which further helps to explain why health-related assistance is not necessarily transformed into improved health outcomes.

For example, Easterly (2007b) argues that corrupt governments have an incentive to minimize the productive capability of the poor because of the potential of creating political activism that would threaten the current political regime. Keeping people in poor health is one way to achieve this goal. This is not a new argument, as Bauer (1971) and Friedman (1958) argue that the political elite in recipient countries will tend to distribute aid in an ineffective manner to generate ongoing streams of payments, thus strengthening their relative position of power. Politicians understand that they will benefit from ongoing foreign aid, creating additional incentives to not only misallocate aid but also to seek out an environment that actually attracts it, including keeping citizens in poor health (Brautigram and Knack 2004).

To illustrate the dynamics described above, consider the case of North Korea. The government requested food and health-related assistance from the United Nations (UN) and certain humanitarian NGOs, but restricted their access from over half of the country in order to hide the magnitude of human suffering from outsiders (Orbinski 2008: 306–9). It eventually became evident that by operating in North Korea, the humanitarian organizations were providing credibility to the government, thus reinforcing the status quo that caused the initial suffering. As James Orbinski, the past president of Médecins Sans Frontières (or Doctors Without Borders), writes "By remaining present, silent and without access to the most vulnerable, we were giving the impression that humanitarian action was possible and that the North Korean government respected basic humanitarian principles … By propping up the regime, aid was not only masking suffering but propping it up" (Orbinski 2008: 308).

In addition to elected officials, special interest and advocacy groups within the recipient country can also distort the allocation of health-related assistance. Consider, for instance, the case of Ethiopia where approximately 60% of health spending is earmarked toward HIV/AIDS initiatives, while less than 1% is allocated toward malaria control (Barder 2009). This allocation is the result of advocacy groups who lobby government agencies and organizations for increased spending on HIV/AIDS prevention. However, a closer look at estimates in Ethiopia indicate that over 65% of the population lives in at-risk areas of malaria and that malaria is responsible for over 25% of deaths in the country. In stark contrast, the HIV/AIDS prevalence rate among adults in Ethiopia is estimated to be 4.4% (WHO 2005). In other words, a reallocation of earmarked funds away from HIV prevention toward malaria prevention could potentially have a higher return in terms of lives saved.

Information

Both donors and recipients must obtain the necessary information to actually target and achieve desired goals. The relevant parties most know what assistance is needed by those

who are suffering, and then know how to best allocate assistance to maximize its impact. The problem is that those involved in the aid distribution process often lack access to the relevant information, as it is discontinuous, dispersed across many individuals, and often contained in inarticulate forms. Donors are capable of specifying goals and what they hope to achieve with health-related aid, but they often do not know where aid is required, who it is needed by, in what locations, and in what quantities. Similarly, those suffering in the recipient countries may know what they need and in what quantities, but they may not know who has the aid or how to get it. The broader issue is that in the absence of the appropriate information, health-related assistance will be ineffective even if appropriate incentives exist.

Donors' Information Problem

In order for aid to be effective, donors must be able to gather critical information, requiring the ability to tap into local knowledge. Donors must recognize where assistance is needed, figure out exactly what is needed and who needs it, evaluate whether or not what they are doing is working, and adapt accordingly. These last tasks require some form of evaluation and feedback. As previously discussed, however, donors must rely on a multilayered bureaucratic process to attempt to solve these information problems. This limits the availability of effective feedback information on effective allocation, and reallocation, of health-related resources.

Ideally, there would be some kind of feedback mechanism that would allow donors to obtain and adapt to changing information. In markets, for example, entrepreneurs have access to prices and the profit and loss mechanism to make decisions regarding the reallocation of resource. In bureaucracies, however, no equivalent mechanism exists. Bureaucratic activity is guided by predefined procedures and protocols. Bureaucratic rules serve as a guide for the behavior of bureaucrats, but the rigidity of these rules limits flexibility and adaptability as information and conditions change. Indeed, bureaucratic procedures and protocols create a separation between private knowledge and political knowledge as predefined rules guide behaviors instead of the "on-the-ground" realities and complexities. Further contributing to the weak adaptability of aid bureaucracies is the absence of clear lines of accountability, as well as the fact that the final recipients of health-related aid have very little opportunity to give feedback to the donor agencies. In other words, the ultimate consumers of aid – those in need – have no mechanism of punishing agencies if they fail. This disconnect contributes to the aforementioned separation between the local information and the information used by bureaucrats in making decisions regarding the use of health-related assistance.

Another issue facing donors is the lack of coordination between the various bureaucracies involved in foreign aid, where information needs to be effectively shared within and across these bureaucracies. This can place heavy administrative burdens on those involved in the delivery of health-related assistance. Consider, for instance, that it is estimated that a medical officer in Tanzania spends 50–70% of their time writing reports and missions (Easterly 2007a). When efforts are diverted into purely administrative tasks this reduces the amount of resources that can help to improve the situation of those in need. Donor agencies are constantly calling for more coordination to relieve developing countries of administrative requirements (see, for instance, Commission for Africa 2005; UN Millennium Project 2005), but Easterly (2007a) notes that there is little sign of improvement.

Consider a recent report by Médecins Sans Frontières, which discusses the delivery of humanitarian assistance in Afghanistan. Among other things, the report indicates that the "Lashkargah hospital is piling up with advanced medical equipment – digital x-rays, mobile oxygen generators, scialytic lamps – donated by a range of states including the United States, China, Iran, and India or through the Provincial Reconstruction Teams (PRTs). This equipment is usually dropped off with little explanation and no anticipation of maintenance; most of it sits in boxes, collecting dust, unopened and unused" (MSF 2010: 2).

Along similar lines, a study of drug donations in the post-tsunami Banda Aceh province in Indonesia found that 70% of the drugs had foreign labels that could not be understood by local workers and were therefore unusable. The study also found that 60% of the donated drugs were not relevant to those affected by the tsunami. Further, 25% of the donated drugs had either expired or had no expiration data. In order to store these inappropriate drugs, humanitarian workers had to sacrifice office space and patient rooms. In total, the report noted that approximately 600 tons of medicine had to be destroyed at a cost of $3 million. Adding to the sad irony of this situation is that the Southeast Asia region, where these wasted drugs were sent, produces a significant amount of the generic medicines used in other humanitarian operations! Indeed, there were indications that the indigenous drug suppliers had the ability to cover the existing drug needs.[6] Similar problems with drug donations can be found in numerous other cases as well (Hechmann and Bunde-Birouste 2007).

Whether it is idle equipment or useless drugs, the absence of effective information serves as a hard constraint on the ability of donors to provide effective health services and goods to those in need. Without the appropriate information regarding where assistance is needed, what assistance is needed, and in what quantities, the result will be waste that fails to contribute to improved health outcomes.

Recipients' Information Problem

In addition to the donors, recipients must also possess adequate information about how to achieve the specific goals of health-related aid. Just like donors, recipient governments often lack the ability to tap into the context-specific information that is critical for success. Recipient governments use the same bureaucratic processes that are used in developed countries and, as discussed, this process tends to be ineffective for tapping into the local information necessary for the effective delivery of health-related assistance. With health-related aid provided by donors, recipient governments, which are often corrupt, still must determine who is in need, what is needed, and in what quantities. This may seem like a simple task, but as the evidence provided earlier indicates, health-related aid has failed to be allocated in a manner that has a consistently positive effect on health outcomes.

To illustrate this, consider a report by the World Health Organization (WHO) which noted that "In the Sub-Saharan Africa region … a large proportion (up to 70 per cent) of [health-related] equipment lies idle due to mismanagement of the technology acquisition process, lack of user-training and lack of effective technical support" (WHO 2000: 10). In other words, donors can provide health-related assistance to recipient governments, but the recipients must know how to effectively utilize that assistance for it to be transformed into improved health outcomes. In addition to allocating the assistance to those who need it, recipient governments must also know how to allocate complementary resources (trained medical staff, repair parts, technicians, etc.) in a manner that allows donations to be used effectively. Recipient governments often lack that information.

Conclusions

This chapter has explored the question of whether international aid can improve global health. In contrast to tackling the more complex issue of promoting economic growth, we have focused our analysis on the effectiveness of aid on the more simple task of delivering health to those in need. Theory and the majority of empirical evidence to date suggest that the answer to this question is "No." While RCTs may be a step in the right direction as a means of evaluation, they should not be confused with a panacea of solving global health problems due to the issues outlined. It is also important to emphasize that the provision of healthcare, by itself, does not necessarily translate into the adoption and use of the assistance provided. This leads us back to the question of what aid can and cannot accomplish in practice.

In the health context, aid can potentially build a hospital, set up a fully stocked immunization clinic, and offer free malaria bed nets. In this context, one could say that health aid is a success, if success is defined as providing more of a predefined good or service. However, successfully providing more of a good or service does not necessarily mean that healthcare providers will show up to work in the hospital, that mothers will bring their children to the immunization clinic, or that the nets will actually be used in a manner to reduce malaria risk. This logic begins to explain why small-scale "successes" can be found in the micro-level data but not in the macro-level data, where the overall relationship between aid and health does not exist. It is not that no one has been helped by health aid interventions, but rather that there is no reason to believe that health aid can *systematically* improve outcomes.

Notes

1. For the purpose of this chapter, we define international aid as official development assistance (ODA) from bilateral and multilateral donors, thus excluding non-governmental organizations and private charity.
2. All health statistics are taken from World Health Organization Data and Statistics 2012.
3. The Organisation for Economic Co-operation and Development classifies social sector aid as aid to social infrastructure and services. It is defined as aid that covers efforts to develop the human resource potential and ameliorate living conditions in recipient countries.
4. Public choice refers to the subfield in economics that uses the rational choice framework to highlight sources of government failures. This is further explained in a subsequent section in this chapter.
5. Least developed countries (LDCs) are those countries defined as such by the United Nations.
6. Data on drug donation in Banda Aceh from Pharmaciens Sans Frontiers–Comite International (2006).

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