DONOR INTERESTS AND RECIPIENT NEEDS: ANALYZING THE INEFFECTIVENESS OF FOREIGN AID TO THE HEALTH SECTOR

by

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(Under the Direction of Abdulhi Osman)

ABSTRACT

This paper seeks to explain why foreign aid to the health sector in the Least Developed Countries has increased yet failed to yield substantial improvements. The Millennium Development Goals associated with health serve as marker for success yet are currently not on track to be met with the current level of progress. This research will evaluate the hypothesis that the discrepancy between donor interests and recipient needs leads to the ineffectiveness of aid. By applying an agency theory framework to the area of foreign aid, this research identifies institutional problems of information and coordination as the primary influence on aid ineffectiveness.

INDEX WORDS: Agency theory, Donor interests, Foreign aid, Health care, Least Developed Countries, Millennium Development Goals, Recipient needs

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DEDICATION

I would like to dedicate this thesis to my parents, Glen and Glenda Hill. They have always provided encouragement when I have needed it the most. They have always been my greatest supporters and for that I am so grateful.

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CHAPTER 1

INTRODUCTION

"Through all our efforts to fight disease and hunger, we can spare people in many nations from untold suffering, and Africa especially. Millions are facing great affliction, but with our help, they will not face it alone. America has a special calling to come to their aid, and we will do so with the compassion and generosity that have always defined the United States."

-- President George W. Bush, February 1, 2003

President Bush is not alone among political figures of the industrialized world who have made declarations directed at fighting disease and improving health care in developing countries. However, there is clearly a discrepancy between declaring the need for improving the quality of life with better health care and actually implementing policies and providing funds that can successfully create change. The health situation in the developing world and most notably the sub-Saharan region of Africa remains poor and unquestionably inferior to the rest of the world. The health crisis is an epidemic not only due to the spread of communicable diseases, but also due to the lack of basic health care which results in the highest levels of infant and maternal mortality rates in the world. The wealthiest countries in the world provide foreign assistance as well as guidelines for how that assistance should be allocated to addresses specific issues. While foreign assistance in the health sector has been on the rise for over three decades,[1] the level of

[1] Aid to health has increased steadily since 1975, with an average annual growth rate of 5.4% in real terms based on data from the OECD.

overall health has virtually stagnated or shown only minimal improvement in many developing countries. This thesis seeks to analyze why increased foreign assistance to the health sector in developing countries has not led to a significant increase in overall health as determined by international health goals.

Health care in the developing world is certainly not the solitary problem these countries are facing. Government corruption, on-going civil wars, and lack of adequate education are among the major issues that are also worthy of research and policy action. However, for the purpose of this thesis I will focus on health care for several reasons. The primary reason is the current worldwide norm of promoting and fighting for human rights. The promotion of human rights is a goal espoused by all developed countries providing foreign assistance. As a result of globalization, human rights are an issue that cannot be ignored or overlooked by any nation. This worldwide awareness has made it the foreign policy of developed countries to create better standards of living and improved social progress throughout the developing world.

Improving health in the least developed countries[2] (LDCs) is not simply a humanitarian response to an overwhelming epidemic. Attention has increasingly focused on public health and health care in general in these areas as a reaction to globalization. With this awareness of the public health crisis in the LDCs, industrialized countries have an obligation to address the health problem and provide assistance for improving the situation. The concept of global human rights

[2] Throughout this thesis the term LDC will be used as it used by the Development Assistance Committee of the OECD. Other organizations such as the World Bank or the United Nations also use the term LDCs to refer to countries with the lowest level of socioeconomic development. While the definition of LDCs is fairly consistent across organizations it is important to note the specific countries I am referring to. As of 2007, the LDCs according to the DAC are: Afghanistan, Angola, Bangladesh, Benin, Bhutan, Burkina Faso, Burundi, Cambodia, Cape Verde, Central African Republic, Chad, Comoros, Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Haiti, Kiribati, Laos, Lesotho, Liberia, Madagascar, Malawi, Maldives, Mali, Mauritania, Mozambique, Myanmar, Nepal, Niger, Rwanda, Samoa, Sao Tome and Principle, Senegal, Sierra Leone, Solomon Islands, Somalia, Sudan, Tanzania, Timor-Leste, Togo, Tuvalu, Uganda, Vanuatu, Yemen, Zambia.

is often used as the main justification for improving health around the world. However, the effects of inadequate health care in the LDCs also produce an interest in improving health for less altruistic reasons. In a globalized world, extremely poor health conditions even if localized in one region can affect the rest of the world. The possibility of health problems in LDCs affecting industrialized countries can serve as an impetus to improve conditions worldwide. Also, there is evidence that the instability created by drastically inferior health conditions can cause serious issues of security that can impact the global community.

On a broad level, there is an ongoing debate between the need for increasing foreign assistance and the idea that there is already too much aid given. While this thesis will focus on the inner-workings of one specific sector of foreign aid allocation, this larger debate cannot be overlooked. This thesis will later show that an increase in aid overall, as well as specifically to the health sector, is a necessary and crucial step toward improving health conditions. However, even with the insufficient amount of aid that is currently provided, stronger focuses on information sharing and coordination between donors would lead to vast improvements in the health sector.

Even with the increased focus on health care and subsequently the increased foreign assistance to the sector, there is a gap in the political science literature. The literature does not adequately address effectiveness in the area of foreign assistance to the health sector. There are of course many challenges associated with analyzing effectiveness in this area. One challenge is singling out healthcare from the myriad of other social problems in LDCs. There are also challenges associated with properly operationalizing and analyzing concepts as broad as health care goals and foreign aid effectiveness. However, the importance of the health care situation and the increase in assistance from donors requires an indepth study that analyzes the models of

foreign aid in an attempt to determine why improvements are not being made. While there is no simple solution, this thesis seeks to provide the initial steps to determine why aid has been ineffective and possible alternatives actions that can be taken in the future. Therefore, this paper will address the research question: What explains the lack of progress toward international health goals despite increased foreign aid? In addressing this research question I will propose the primary hypothesis: *Ineffectiveness in the health sector can be attributed to a lack of information and coordination of foreign assistance.*

The next three chapters will outline the current status of foreign assistance to the health sector and why it has proven to be generally ineffective. Chapter two will provide a review of the relevant literature associated with the research question. Chapter three explains the methodology used throughout the thesis. In this chapter I will provide explanations of key concepts in the research: official development assistance to the health sector and international health goals. I will also provide an explanation for the choice of qualitative research for my topic. In chapter four I will analyze my key hypotheses, which address the reasons behind the ineffectiveness of foreign assistance despite the increasing funds and interest in the health sector. Chapter five will then provide a conclusion concerning policy implications and possible prescriptions surrounding my hypotheses.

CHAPTER 2

LITERATURE REVIEW

This chapter will assess the relevant literature on the topic health care in the LDCs and specifically why it has become a focus of foreign aid. It will also identify the theory that will be used throughout this thesis.

Health and Globalization

In order to understand the significance of the research question I will begin by addressing the important role of globalization in bringing attention to public health and health care in the LDCs. Globalization[1] influences every aspect of politics, economics, and human interaction throughout the world. With the spread of globalization, the most salient issues in every country come to the forefront of the global agenda. Not only is the world aware of the problems and issues within distant countries, in some cases the world has a responsibility to address these problems. For many Western, developed countries, there are obvious economic benefits to globalization. However, with these benefits also come responsibilities to promote development in other countries. Health care is one of the unavoidable problems that have become a concern of the global community and clearly impedes development in many of the LDCs. As a result,

[1] Globalization is often used as an ambiguous or all-encompassing term to explain global or international changes. For the purpose of this thesis I will refer to globalization as it specifically relates to the health sector. According to the WHO, globalization as it applies to health refers to the impact on health of growing international trade, improving global communications, and increasing flows of goods, services and people.

globalization has played a large role in the increase in interest and foreign assistance to the health sector in LDCs.

Globalization has produced opposite effects on health care. In one sense, globalization has been beneficial for the improvement of health care in terms of innovation and technological advances. This beneficial quality of globalization is of course not restricted only to health care. However, globalization has undeniably assisted with the ability to disseminate information about health, improve the delivery of healthcare services, and improve the management of communicable diseases, among many other healthcare related activities (Feachem, 2001). On a broader level, the economic benefits of globalization can also indirectly lead to improved health. Developing countries that have made a significant effort to globalize with increased trade and reduced import tariffs have had faster economic growth than other developing countries (Dollar, 2001). Economic growth is necessary to provide and sustain public goods such as health care. If the economic growth within the country is widespread among the population it can also reduce poverty. A decrease in poverty is directly related to an increase in health for a population (Labonte, 2004). In the simplest terms, an increase in wealth leads to an increase in health and vice versa.

There is also a strong argument for the negative aspects of globalization on health care. Globalization has led to industrialized countries actively recruiting the highly educated individuals, such as doctors, from the LDCs.[2] This brain drain among the poorest countries moves qualified doctors away from the areas where they are most needed to further improve healthcare in more developed countries. One of the most widely criticized effects of globalization is the effect on local cultures and the health is no exception. Along with unhealthy

[2] It is estimated that in the case of 20 African countries more than 35 percent of nationals with a university education are now living abroad (International Organization for Migration 2001).

dietary changes, increased tobacco and drug use has substantially increased in developing countries as result of globalization. Along with the obvious negative health consequences of drug use is the increased probability of transmitting blood-born diseases such as HIV/AIDS (Sachs, 2001). Another major consequence of globalization is related to the spread of disease. The transmission of diseases is not only important in the sense of the detrimental effects on the developing countries but also to international community as well. Tourism, migration, and business travel are just a few of the many ways diseases can be transmitted back to industrialized countries (Feachem, 2001). These are certainly not intended to be exhaustive lists concerning the positive and negative effects of globalization on public health. Widespread debate exists on whether it is actually doing more harm than good. Rather, for the purpose of this thesis, this description of the main consequences of globalization on health is simply intended to show that globalization has significantly impacted the public health situation.

While the pros and cons of the effect of globalization on pubic health are debatable, it is undeniable that globalization has brought attention to health care in LDCs. The impact of globalization can be seen as a two-fold reaction to public health in the developing world. Most noticeably, it creates awareness of the problem. As I will discuss, human rights cannot be ignored due to globalization. Industrialized countries have a responsibility to adhere to international norms. Therefore, globalization not only creates international norms such as human rights that become universal, but it also serves as mechanism to ensure every state's responsibility to these norms. Globalization also impacts public health by creating awareness among the industrialized countries that poor health conditions and the product of those conditions can reach and influence the rest of the world (Labonte, 2004). The reality of the spread of disease from LDCs to the industrialized countries makes for an increased desire to

address the problem. These two broad factors associated with globalization are perhaps the most prominent reasons for the increase in foreign assistance and intervention to the health sector over the past three decades. The following sections are intended to further demonstrate the two ways in which globalization has brought attention and foreign assistance to the issue of health care in LDCs: 1) As a humanitarian concern and 2) as a security concern.

Health as a Human Right

Before beginning my research it is important to understand the basis for why health care is considered a basic human right. This idea can be attributed to Maslow's (1943) hierarchy of human needs. According to Maslow, the needs of individuals are organized in a pyramidal structure with physiological needs at the base. These are the most basic needs that an individual must meet in order to survive. These needs include access to food and water, which are luxuries that many in the most impoverished areas of the developing world do not have access to. If an individual cannot meet these basic needs, they have no chance of advancing beyond these physiological needs. The next level of the pyramid is the safety of the individual. This is the stage when the individual's health and well-being becomes salient. At this level the individual cares more about his or her health in broader terms. At the lowest level, health is based on surviving malnutrition and dehydration but at this level, disease and other general physical ailments become a factor. In many cases health needs that are related only to food and water are not being met, therefore it is obvious that further health considerations are not being met as well. Further development beyond physiological and safety needs toward love and belonging, self-esteem, and finally self-actualization are not even considered when these needs are not met.

This concept of a needs hierarchy is further expanded by Park (1984) in terms of political development. He determines that the motivations of human behavior drive development. Therefore, without meeting these basic needs, individuals cannot strive to advance beyond them to achieve further development. This theory is based on human goals rather than grounded in any one culture or social structure. This cross-culture applicability provides the optimal context for understanding the lack of effective health care in the developing world. Without access to their health care needs, they are unable to pursue further goals. This disregard for health in the LDCs is a human rights offense that is not only detrimental to the individual health of the people but also to the further development of many countries in the developing world. If the improvement of human rights is an authentic goal of foreign policy then improvement of basic healthcare would be the obvious place to begin.

In 2000, the United Nation's Universal Declaration of Human Rights[3] which were created in 1948, served as the basis for the Millennium Development Goals (MDGs). The earlier declaration created a consensus among the member states that human rights and fundamental freedoms are applicable to every person all over the world (Mahoney, 2007). The MDGs were then established by the United Nations to provide specific goals related to eradicating poverty by improving healthcare, education, and equality to be reached by the year 2015. While the MDGs do provide quantitative targets to reach, they are more broadly focused on human rights. "These Goals [MDGs] and the related targets have not been drafted in what could be called 'rights language'. This does not mean that they do not have a central human rights dimension. Each of these goals can be addressed in terms of binding human rights obligations based on treaty and

[3] The Universal Declaration of Human Rights was a reaction to the human rights violations of World War II. Other countries had established similar declarations of human rights applicable within their individual countries but it was the first to create an explicit international obligation to uphold human rights for every person.

customary international law."[4] The World Health Organization (WHO) has been especially vigilant in advocating "the highest attainable standard of health as a fundamental right of every human being" since the inception of the organization (WHO, 2003). The work of the WHO covers almost every feasible aspect of global health, yet the organization remains an important force for reaching the MDGs and promoting the association between health and human rights.

Even beyond these official declarations of promoting human rights is a more general international consensus that basic rights should be a goal. Increasingly, human rights have been a guiding factor for international policy decisions (Vincent, 1986). Whether or not promoting human rights is actually a goal of the policy or simply a justification to achieve other policy goals, it is still in the forefront of foreign policy decision-making.[5] While advancing human rights has clearly become an international goal, the U.S. has particularly made use of the cause as way to justify foreign policy. Human rights became a foreign policy goal in the U.S. due largely to the national identity associated with moral obligation to defend the human rights of all human beings (Donnelly, 2003). Because the U.S. was founded on the concept of "unalienable" rights, many American citizens as well as politicians believe that it is their moral obligation to defend the rights of all humans, not just those within the national borders. However, in many cases this is more of a moral ideal rather than a policy that is always consistently practiced in reality. The issues of morality versus practicality explain the high levels of rhetoric associated with international human rights and considerably lower levels of action (Gomez, 2007).

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[4] Skogly, 2006. P. 143

[5] There is significant debate on the level at which human rights actually play a part in the foreign policy of a given country. The scope of that question cannot be covered in this paper. There are clear examples that human rights have not been consistently championed equally around the world or in all areas that apply to human rights. However, it is important to note there has been an undeniable increase in the advancement of human rights in foreign policy as a main goal or at the least an intended effect of a given policy.

It has also been suggested that the U.S. has portrayed itself as an advocate of human rights to fulfill a void left by religion (Demerath, 2007). There is contradictory view of American religiosity abroad in which Americans are viewed as highly religious individuals yet the separation of church and state alludes to a highly secular society. As free exercise of religion has become a more popular concept worldwide, defending human rights has become the outlet to express national morality as opposed to religion. In this way, the U.S. can export both secularization as well as morality in a nonreligious disguise. As other nations have continued accepting this form of secularization, so have international organizations. International treaties and declarations are not religious in nature, but still manage to encourage morality by advocating human rights.

Despite the potentially different reasons for becoming interested in human rights, there has been an increase interest across the board. From the Universal Declaration of Human Rights to the Millennium Development Goals, the theory of universalism has been more applicable to human rights than the opposing theory of cultural relativism.[6] The concept of universalism has guided the universality of rights as well as the universality of obligations (Skogly, 2006). The connection between the universality of rights and obligations has been partially been maintained with foreign assistance. Health, education, poverty, and gender equality have generally been the focus of these 'human rights' areas of foreign assistance. While the importance of the other human rights mentioned, as well as the many others not mentioned, should not be degraded, health care has received an especially high amount of concern among developed countries. It is not the intention of this thesis to provide a definitive answer to why health has increasingly received more official development assistance (ODA) in the last three decades as opposed to

[6] An international consensus has been demonstrated by such documents as the UDHR among others, that human rights are, by definition, universally applicable. Therefore, cultural relativism only becomes salient in the limited situations of exceptions and differing principles of interpretation (Donnelly, 1984).

other sectors associated with human rights or development in general. However, I will discuss the issues of security and globalization for the purpose of explaining my research question and I believe it may provide some insight into the answer.

The Health Crisis and Security

Human rights aside, the effects of inadequate health in the developing world create a multitude of further problems that ultimately can result in security problems for the countries involved as well as the rest of the world. The idea of poor health conditions and disease being detrimental to the survival of a state is not a new concept. An integral part of Jared Diamond's (1997) hypothesis in *Guns, Germs, and Steel* emphasizes the extreme effects of disease on entire regions and groups of people.[7] He proposed that death of entire populations of people could be attributed to the susceptibility to certain diseases throughout history. The current health crisis even goes beyond the scope of Diamond's theory. There has been an introduction of new diseases and an inability to control their rampant spread, such as HIV/AIDS. However, the developing world is also suffering from other communicable diseases for which there are treatments, such as malaria. Along with the spread of disease, there are basic health care problems that have crippled development and led to increased conflict. The conflict that may result from poor health conditions has the possibility to affect not only the country itself, but also the entire region, and possibly have a worldwide impact. As the health crisis has continued, there has been a strong focus on the link between health and a country's level of security. The high rates of disease and general poor quality of health for an entire population have in many instances created a chain reaction of events that can in the worse case scenario lead to state

[7] Diamond referred to the epidemics that accompanied European expansion and colonization between 1500 and 1800. There are still instances of the global spread of disease but we have developed better way to address disease and infection since then.

failure. State failure, which most often occurs and has the most potential to occur in sub-Saharan Africa, heightens the potential for regional conflict, further impeding any progress toward development.

The downward spiral caused by poor health conditions begins with instability at the state level. With the health levels consistently low among the general population in LDCs, economic productivity is hampered by numerous consequences of poor individual health conditions such as: decreases in worker productivity, labor shortages, reductions in per capita income, and consequently reductions in gross domestic product. An unhealthy population also loses incentive to invest in other public goods such as education, which furthers the inability to improve economic productivity (Price-Smith, 2002). This trend of decreased worker productivity leads to decreased economic stability, which creates instability in every aspect of the state. Poor governance and increased violence build on this instability, creating a security problem for the state and surrounding region.

Poor health conditions exacerbate all the qualities that reduce state capacity. The decrease in economic productivity creates higher income inequality within the state and among the state and developed countries. Sub-state violence often crosses over into surrounding states in the region. Sub-Saharan Africa is an example of a region with ongoing conflicts that are partly fueled by the poor health conditions that plague the region (Labonte, 2004). There is no singular factor that can be designated as the cause of conflict, or potentially state failure. Education, economics, and government corruption are among the multitude of other factors that play a role in the instability of a state. However, extremely poor health conditions in a state are undeniably a

component in the cycle that leads to violence. Infant mortality rates were even found to be one of the most significant variables associated with state failure (State Failure Task Force, 1999).[8]

On a system level, it is in the interest of industrialized countries to address the issues of health and disease control. The instability created within a country or region often has a profound effect on industrialized countries. Of the 113 cases of state failure documented between 1957 and 1994, the U.S. intervened militarily in almost every case (Sachs, 2001b). Intervention consisted of activities including direct combat as well as peacekeeping missions and protecting U.S. property. These numerous military engagements are not the only threat security on a global level. Communicable diseases can rapidly spread from one location to another, with HIV/AIDS being the prime example. Industrialized countries are at risk as a result from infectious disease for reasons other than the obvious spread of disease across borders. There are also the direct financial costs associated with responding to health crises. For all of these reasons, as well as broader economic and political interests I will discuss, donor countries have become specifically interested in health care in LDCs. Therefore, this paper seeks to address why the increasing interest in health, and subsequent increase in foreign assistance to health, has yet to produce significant results in line with international health goals.

Theory

The theories most often applied to discussions of foreign aid are those associated with development. The two main subsets of theory associated with development, dependency theory and modernization theory, provide vastly differing outlooks on the reasoning behind foreign assistance. Both theories arise as an aspect of globalization with very different views of the

[8] In a study of state failure over the period 1957 to 1994, of all explanatory variables that were examined, three were most significant: infant mortality rates; openness of the economy, and democracy.

effects. Modernization theory assumes that development can be achieved by following a pattern set forth by those countries that have already experienced development (Huntington, 1991). Modernization theory directly supports the concept of foreign assistance through the belief that developing countries cannot reach the level of development without guidance from the industrialized countries. This theory is often criticized for being inherently ethnocentric which resulted in the development of dependency theory as a reaction to modernization theory. Dependency theory is inherently against foreign intervention into developing countries. It states that a lack of development in the LDCs is a direct result of foreign involvement. “Historical research demonstrates that contemporary underdevelopment is in large part the historical product of past and continuing economic and other relations between the satellite underdeveloped and the now developed metropolitan countries. Furthermore, these relations are an essential part of the capitalist system on a world scale as a whole” (Frank, 1972).

While both dependency and modernization theory provide perspectives on why aid is given, an even simpler perspective can be taken away from these theories. The driving force behind the desire of donor countries to provide aid and the reason they want recipient countries to be successful is capitalism. Therefore as the connecting factor it is assumed that capitalism plays the central role. Whether capitalism is said to be the reason for underdevelopment, as in dependency theory, or there is a need to make other countries capitalist, it remains the connecting factor. Donor countries assist LDCs in development with the expectation that the countries will become profitable trading partners. Adam Smith’s *Wealth of Nations* (1776) stated that a country’s wealth is directly related to the prosperity of other countries. For example, “The U.S. Commerce Department estimates the market value of U.S. foreign direct investments to be $2.1 trillion, of which $500 billion is in developing countries” (Sachs, 2001). Not only is

improving health a goal in order to increase possible trading partners, but also the possibility of state failure in a LDC could have economic costs for donor countries. Therefore, from this perspective, the motivations of donor countries are neither to repress the recipient countries as dependency claims nor to alter the culture of the recipients as modernization claims. Rather, donor countries want to provide the assistance to raise the possibility of economic trade and reduce instability within the current LDCs.

With these theories of development in mind, the purpose of this thesis is not specifically to understand why aid is given. Rather, this thesis seeks to understand the reasons behind ineffectiveness of foreign aid. To focus more clearly on the ineffectiveness of aid, one must understand the institutional perspective. More specifically an institutional economic approach based on the 'agency theory' provides a thorough analysis of the relationship between donor and recipient countries. Institutional economic thought examines how informational problems affect organizational performance, which differentiates it from neo-classical thought which assumes perfect information. Initially agency theory was applied to companies which are hierarchically structured and contain a 'principal' delegating instructions to an 'agent.'

Agency theory is based on information, organization, and efficiency. These elements lend this theory, which is primarily used for economics and public administration, to be especially useful in understanding the relationship between donors and recipients. Agency theory addresses the situation in which the principal (the donor) delegates work to the agent (the recipient). One problem that can arise with this relationship is when the goals of the principal and agent conflict and it is difficult for the principal to verify what the agent is actually doing. Secondly, there is the problem that the principal and agent may prefer different actions because of the different

risks involved (Eisenhardt, 1989). These problems are clearly present in the donor and recipient relationships involving foreign aid allocation to the health sector.

More recently it has been realized that agency theory could be applicable on a macro level pertaining to foreign assistance donors and the recipient countries with the donors as the principals and the recipients as the agents (Killick, 1995). With ODA or health aid specifically it must travel through either bilateral or multilateral channels. Both forms of aid create problems with information between the principals and agents concerning information. This can ultimately explain the lack of successes within the health sector in the LCDs. Accroding to Carr (1998. P.44), "…at each link in the [aid delivery] chain, there exists an agenda which may or may not be consistent with the agendas both below and above it. These inconsistent and often conflicting agendas in the aid chain create difficulties in the determination of expected outcomes for any particular project." When evaluating the proposed hypotheses, the relationships between the multiple principals and agents will be further outlined. The hypotheses that will be analyzed in this thesis will draw from agency theory and assume donor as the principal and recipients as the agents. Additionally, the concepts associated with agency theory involving efficiency, information, and organization will be applied to the donor and recipient relationships in the foreign aid process.

CHAPTER 3

METHODOLGY

This chapter will present the hypotheses and provide a brief conceptualization of the independent and dependent variables associated with the primary hypothesis: foreign assistance to health and international health goals. It will then elaborate on the methods used to conduct the analysis of the hypothesis. Additionally, this chapter will also clearly identify the two key factors, associated with the main hypothesis; foreign aid for health is increasing and health goals are not being met.

Variables

By using the MDGs directly related to health as the dependent variable, the issue of intervening factors arises. If taken collectively, the MDGs are intended to end poverty. Therefore, it should not be the goal to simply improve one issue, such as health care, and disregard the other goals related to education, equality, hunger, and the environment. It has been recognized that without addressing all aspects of the problem, each individual goal is unlikely to be achieved. While of the goals are indeed dependent on each other, there is still a clear distinction between the different issues. Just as ODA can only be categorized into one sector, MDGs can have only one overarching goal. MDGs focused on other issues may have an impact on health but it would be secondary to the main goal. Therefore, even moderate improvements on the non-health related goals would translate into improvements in health care.

One could argue that one sector is more important in development than another or possibly that improvement should begin in one sector and then move on to other areas. However, in accordance with the way in which ODA is distributed and the MDGs were created, there appears to be an emphasis on multi sector allocation. This suggests that not just one sector can be the focus of attention. This interconnectedness of goals for development does not mean that the sectors should not be researched separately in order to find the best way to make improvements broadly. Therefore, by acknowledging the obvious interdependence of goals, this thesis will continue to focus on foreign assistance and goals specifically related to the health sector. The qualitative nature of this study will allow, when necessary, to discuss the possible overlapping of sectors as they relate to the goals and allocation of assistance.

It is essential to consider the independent variable, foreign assistance to health in the proper context. Health is a component of development that cannot be completely separated from every other component of development. As I discussed in the introduction, the cycle that leads to development is influenced by countless other intervening factors such as lack of adequate education, income inequality, and regional violence to name a few. Aid to health as it is reported to the DAC, is affected by the interconnectedness of the many problems associated with poverty. When being reported to the DAC, the assistance can only be assigned one sector and purpose code. Therefore, for activities that cut across several sectors, aid can only be designated to the sector where it has the most direct purpose. The sectors specified for “health” does not encompass many of the activities that may have a direct effect on health such as water sanitation or nutrition. The DAC is currently working to develop a system of reporting that involves multiple purpose coding which can encompass a more varied range of health activities (OECD, 2004). With these considerations in mind, the “aid to health” variable still provides information

toward monitoring trends and assessing the magnitude of aid to this sector. It is also important to note that this discrepancy in reporting aid to health only furthers the hypothesis of this thesis. If anything, the errors in reporting only allude to the probability that aid to health is underreported because it spans so many different activities. Therefore, aid to health is possibly on the rise at more significant rate than will be shown in this thesis.

Research Design

This goal of this thesis is to test the primary hypothesis: *Ineffectiveness in the health sector can be attributed to a lack of information and coordination of foreign assistance.* In order to test this hypothesis, this thesis will separately evaluate the independent variable, foreign assistance to health, as it relates to both donor interests and recipient needs. It will explore these two perspectives as they relate differently to their effect on reaching the health goals by analyzing the relevant policy literature. These aspects of the main hypothesis can be turned into three testable hypotheses:

H1: Foreign assistance allocation based on donor interests increases ineffectiveness in the health sector.

H2: Foreign assistance allocation based on recipient needs increases ineffectiveness in the health sector.

H3: The lack of information and coordination in foreign assistance allocation increases ineffectiveness in the health sector.

With these hypotheses outlined, it is necessary to discuss the practical conditions of the thesis. This thesis is specifically focusing on the time period from 1990 to 2006. The time parameter was chosen for several reasons related to health and foreign assistance during the period. First, 2006 was chosen because it is the most recent year with available and complete data in both the areas of health care and foreign assistance. Second, in the 1990s there was a noticeable decline in total official developmen assistance, which was especially interesting in comparison to the increase in aid to health at that time. Despite the recent increase in total foreign assistance in recent years, this time period containing the interesting dichotomy serves as a good place to begin. The third reason this time period was chosen was that two of the MDGs related to health specify 1990 as the initial point of reference for the improvement of the health factor. In accordance with this point, the year 2015 is also important to keep in mind for the purpose of this thesis. While speculating about future events is not a scientific method, in this case 2015 must be kept in consideration to determine the relative success of the MDGs as they make progress.

The spatial parameter of this thesis is limited to the LDCs. LDCs are an income group that is used by the DAC to categorize how aid is allocated. LDCs are concentrated in sub-Saharan Africa and South Asia. While foreign assistance is allocated to countries other than LDCs for health, there is a stronger connection to health and assistance than other countries. They are also the countries that are most reliant upon aid for improving health. Health problems take many different forms worldwide. For example, heart disease and cancer are problems plaguing industrialized countries. Yet LDCs are facing health problems that are far less advanced in terms of care and treatment such as decreasing disease in order to improve maternal and child mortality rates.

Extensive quantitative research has been conducted as a way to explain the motivations behind giving foreign assistance to developing countries. Traditionally, motives are categorized by two models: the donor interest and recipient need models. The main assumption of the recipient need model is that aid is given proportionally to the economic and welfare needs of the recipient countries. Variables were assigned to represent both the economic and social deficiencies within a given country and regressed against both bilateral and multilateral aid. These variables consisted of GDP per capita to represent the economic aspect; physical quality of life index as an aggregate representation of the basic social quality, and population as a control variable (assuming larger populations would receive more aid). This model provides no explanatory power for the allocation of bilateral aid. However, it does indicate, as one would expect, that multilateral aid is given in terms of recipient needs.

The main assumption of the donor interest model is that aid is distributed according to the foreign policy interests of the donor country. Variables associated with donor interest are considerably more varied, considering the large sphere of possible interests among different donors.[1] The wide array of donor interests can be subsumed into three categories: political and security interests, donor investment interests, and donor trade interests. Variables representative of these individual categories were once again regressed against bilateral and multilateral aid and opposite results were produced which provided explanatory power for bilateral aid but not for multilateral.[2] This discrepancy among the two preeminent models for explanation as well as the ambiguity in predictive power are a prime example of the need to address issues of development assistance from a qualitative standpoint. To look at only the numbers associated with economic

[1] I am expressing the data as it has been presented in previous studies. It is not my opinion that donor interests are more varied that recipient needs. It is in fact another reason that quantitative data does not provide adequate explanation of the donor-recipient relationship.

[2] Maizels, 1984. See source for full statistical analysis.

and social underperformance based on aid allocation allows for an incomplete analysis of aid effectiveness. A more complex, integrated approach to foreign assistance is needed to properly analyze the reasoning behind motives. The models previously mentioned address only the motives for aid allocation, which even fails to produce a concise model. Yet, this leaves the field of research open to address the more focused question of which method creates greater aid effectiveness within the recipient country. The motives of donor countries directly relate to the results of aid in recipient countries. There is no reason an integrated approach could not provide a more balanced way of allocated aid that will both address the interest of donors as well as the needs of the recipients. After all, foreign assistance that does not produce results is worthless to both the recipient and donor countries involved.

This thesis will attempt to take a more analytical approach to donor interests and recipient needs. The thesis will compare the two models in the context of agency theory as they relate to foreign assistance to health since 1990. Foreign assistance to the health sector has been unique in that it is often allocated by the donor countries in terms of humanitarian assistance, yet it is certainly not without underlying motivations to benefit the donor. Foreign assistance in general is often thought to be solely used by the donor country to gain power. However, the health sector may be the one area that bridges the gap between donor interests and recipient needs. This is why it is important to consider donor interests and recipient needs separately initially. The policy prescriptions section of this thesis will use the analysis of the separate models to consider an undoubtedly more complex, but possibly more explanatory model of foreign assistance. By comparing donor interests and recipient needs as they relate to the health sector, within the given time frame, and in the LDCs, this thesis seeks to provide more insight into the how they are applicable to foreign aid in general.

There is a considerable gap in the literature concerning the actual effects of aid to the health sector and the overall effectiveness. Studies focused on aid volume and economic growth have generally concluded that foreign aid has no substantial influence on economic growth in the recipient countries (Burnside and Dollar, 1996). However, the field is lacking a micro-level analysis of the institutions involved in aid allocation. Within the expansive realm of foreign aid, the health sector stands out as a particularly interesting case of increased funding which has not produced the desired results. This thesis seeks to serve as a starting point for more research in this area. According to Buse and Walt, "There has been no rigorous or systematic health sector review of which mechanisms work best, how contextual factors affect coordination, what motivates the different actors to support coordination efforts or indeed, how coordination makes a difference to health systems" (Buse and Walt p.461, 1997). Additionally, the academic literature that focuses on foreign assistance tends to have a heavy bias toward quantitative methods. While these methods are no doubt essential to understand broad trends, in many instances quantitative analysis lacks the ability to realize the intricacies of more specific matters, such as the effectiveness of health aid.

The data used to support the main hypothesis was primarily gathered from the OECD's online database, the Creditor Reporting System (CRS) and UNICEF's monitoring system for the MDGs. The CRS not only provides aggregate statistics for foreign assistance, but is intended to show trends for sectoral analysis as well. The limitations of the CRS system were also previously outlined in the literature review. UNICEF's monitoring system is provides the most recent and extensive data associated with the specific targets of each MDG related to health. After confirming that both aid was increasing and health goals were not being met, this thesis takes further measures to analyze a range of possibilities that may contribute to this situation. In order

to test the hypotheses the two standard models of foreign aid were analyzed (donor interest and recipient need) as well as new integrated model based on agency theory. Therefore, this thesis will primarily add to the literature by addressing aid to health from a more complete perspective than past research that remained primarily quantitative.

My research question contains two central assumptions that will be supported with data in the following section. The first assumption is there has been an increase in foreign assistance to the health sector. The second assumption is that international health goals have are not currently being met. In order to justify my hypothesis, I will separately and thoroughly evaluate the two central assumptions as they are related to the independent and dependent variables in this thesis. With this analysis, I will provide supporting data that will verify these assumptions.

Foreign assistance to health has increased

The independent variable, foreign assistance to health, comes from multiple sources including governments, charities and non-profit organizations. Governments provide the vast majority of these funds either as bilateral donors or through multilateral channels. For the purpose of this thesis I will be referring to the aid given by both individual bilateral donors and multilateral contributions funded by those donors as reported to the Development Assistance Committee (DAC). Reports from the Organization for Economic Cooperation and Development (OECD) indicate that official development assistance (ODA) fell throughout the 1990s and has only begun to rise again in recent years (OECD, 2000).[3] This decline in ODA is often attributed to 'aid fatigue' from the previous four decades as a result of the fear that foreign assistance had

[3] ODA is officially defined by the OECD as grants or loans to countries and territories on Part I of the DAC List of Aid Recipients (developing countries) which are: (a) undertaken by the official sector; (b) with promotion of economic development and welfare as the main objective; (c) at concessional financial terms. In addition to financial flows, Technical cooperation is included in aid. Grants, loans and credits for military purposes are excluded.

produced a dependency relationship with developing countries (Tarp, 2000). However, aid to health has increased annually since 1973 and was not adversely affected by the decline in overall ODA during the 1990s (OECD, 2004). The following figure compares the overall ODA to ODA committed to the health sector from 1990 to 2006 specifically for the LDCs. Both figures of are in terms of constant USD (2005).

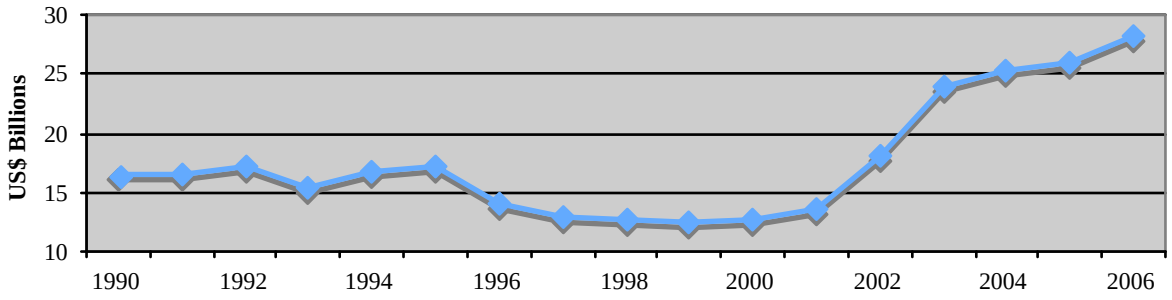

Figure 3.1 Total ODA to LDCs 1990-2006

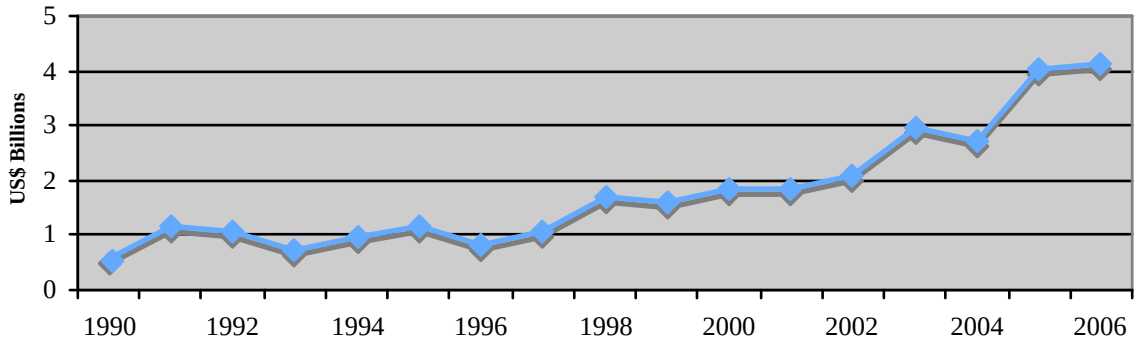

Figure 3.2 Health ODA to LDCs 1990-2006

By viewing the previous figure one might assume that the steady increase in ODA to health has created improvements within the sector. However, despite the increase levels of health have remained extremely low in most LDCs. This is the result of two main reasons associated with ODA. First, even though aid to health has been on the increase, it is not at a fast enough rate to reach the MDGs. As this thesis will later discuss, much more funding is needed in this area. Secondly, health is only one aspect of a greater goal to reduce poverty and all the factor for reducing poverty are interconnected. Therefore, increases to only the health sector are not likely to have a significant effect if areas such as education are not also adequately funded. These reasons will be elaborated on further in this thesis when analyzing the ineffectiveness of aid.

In order to categorize how aid is spent, all aid provided to the DAC must be assigned to a sector. Within that sector a purpose code allows for aid to be designated not only to a general sector of health, but also to a particular activity. Health activities are classified by the DAC under the broad category of "Social infrastructure and services." Under the sub-sector of "Health," general health and basic health are broadly defined while there is a separate category that deals only with population health, which includes a significant sub-category for HIV/AIDS. This thesis will focus primarily on general and basic health care needs as they relate to international health goals. However, the significant impact of population health cannot be completely overlooked when addressing aid allocation. Considering that "aid to health" can be an ambiguous concept, the DAC provides detailed information concerning the three overarching sectors, with subgroups focused on individual aspects of health care. The following table outlines the different areas of aid to health as well as how aid is spent in each category.

Table 3.1 ODA sub-sector for Health

Health	*Description*	*Clarifications on coverage*
General Health	Health policy and administrative management	Health sector policy, planning and programs; aid to health ministries, public health administration; institution capacity building and advice; medical insurance programs; unspecified health activities.
	Medical education/training	Medical education and training for tertiary level services
	Medical research	General medical research (excluding basic health research)
	Medical services	Laboratories, specialized clinics and hospitals (including equipment and supplies); ambulances; dental services; mental health care; medical rehabilitation; control of non-infectious diseases; drug and substance abuse control
Basic Health	Basic health care	Basic and primary health care programs; paramedical and nursing care programs; supply of drugs, medicines and vaccines related to basic health care.
	Basic health infrastructure	District-level hospitals, clinics and dispensaries and related medical equipment; excluding specialized hospitals and clinics.
	Basic nutrition	Direct feeding programs (maternal feeding, breastfeeding and weaning foods, child feeding, school feeding); determination of micro-nutrient deficiencies; provision of vitamin A, iodine, iron etc.; monitoring of nutritional status; nutrition and food hygiene education; household food security.
	Infectious disease control	Immunization; prevention and control of malaria, tuberculosis, diarrheal diseases, vector-borne diseases (e.g. river blindness and guinea worm), etc.
	Health education	Information, education and training of the population for improving health knowledge and practices; public health and awareness campaigns.
	Health personnel development	Training of health staff for basic health care services.
Population policies/ programs and reproductive health	Population policy and management	Population/development policies; census work, vital registration; migration data; demographic research/analysis; reproductive health research; unspecified population activities.
	Reproductive health care	Promotion of reproductive health; prenatal and postnatal care including delivery; prevention and treatment of infertility; prevention and management of consequences of abortion; safe motherhood activites.
	Family planning	Family planning services including counseling; information, education and communication activities; delivery of contraceptives; capacity building and training.
	STI control including HIV/AIDS	All activities related to sexually transmitted diseases and HIV/AIDS control
	Personaldevelopment for population and reproductive health	Education and training of health staff for population and reproductive health care services

Not every sub-sector of health aid has grown at the same rate. While some areas have maintained continued growth, some have stagnated, and others have experienced exponential growth. However, this matter of uneven distribution in the health sector will be addressed later in the thesis.

International Health Goals are not being met

In order to determine that international health goals, the dependent variable, are not currently being met it was important to distinguish a set of goals that were agreed upon by the international community. With a plethora of committees, organizations, and declarations to examine it was important to find a set of goals that exemplify an overarching consensus for addressing health. The Millennium Development Goals were developed to address world poverty but have specific goals aimed at improving health care. It was also important to find a set of goals that were directly tied to the purpose of the DAC. The members of the DAC first committed to International Development Goals (IDGs) in 1996 as a comprehensive set of goals to address the needs of the developing world. The IDGs were broad goals but served as the basis for the MDGs that were later adopted at the Millennium Summit of the United Nations in September 2000. The MDGs addressed the same major areas, but with more specific targets added to each goal. As I have discussed, poor health is an integral part of the cycle that perpetuates poverty. These goals, along with the other five, provided a comprehensive plan to reduce ultimately eliminate poverty. The following chart presents the three of the eight MDGs that directly address health as well as the targets and indicators for each goal.

Table 3.2 Millennium Development Goals related to Health

Goal	*Target*	*Progress Indicators*
Reduce Child Mortality	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.	Under-five mortality rate, Infant mortality rate, Proportion of one-year-old children immunized against the measles
Improve Maternal Health	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	Maternal mortality ratio, Proportion of births attended by skilled health personnel
Combat HIV/AIDS, Malaria and Other Diseases	Have halted by 2015 and begun to reverse the spread of HIV/AIDS & Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	HIV prevalence among pregnant women aged 15-24 years, Condom use rate of the contraceptive prevalence rate Condom use at last high-risk sex , Percentage of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS, Contraceptive prevalence rate Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years, Prevalence and death rates associated with malaria, Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures, Prevalence and death rates associated with tuberculosis, Proportion of tuberculosis cases detected and cured

Source: United Nations Development Program, 2007

Almost every indicator associated with the health MDGs has shown some level of improvement worldwide, or at the least not worsened since the development of the goals. However, these improvements can be deceiving when compared to the projected improvement that needs to take place in order to reach the goals. Also, improvements have occurred least in the LDCs. There is encouraging evidence that it is still possible to reach the goals set for health by the deadline of 2015 (Sachs, 2001a; Sachs, 2005; Travis, 2004; UNDP, 1998). However, reaching the goals at this stage would require a considerably larger amount of funding as well as a new perspective on the priorities of ODA to the health sector. The current status of the health

MDGs does not look promising if progress continues at the same rate. Sachs (2001) succinctly states the problem with reaching the MDGs: "…On our current trajectory, those goals will not be met for a significant proportion of the world's poor. Success in achieving the MDGs will require a seriousness of purpose, a political resolve, and an adequate flow of resources from high-income to low income countries on a sustained an well-targeted basis." A closer look at the current progress of the MDGs is in order to determine if in fact the health goals are being met. I will next provide a summary of the data concerning each MDG targeted specifically for health.

Reduce Child Mortality: According to the main target of this goal, the under-five mortality rate[4] should be reduced by two-thirds between 1990 and 2015. In 1990 the under-five mortality rate for the world was 93 deaths per every 1,000 live births as compared to 180 deaths in the LDCs. In 2006, those numbers had only dropped to 72 and 142, respectively. Over the course of 16 years, neither the world total nor the total for LDCs has even approached the halfway mark for this goal with only nine years remaining (UNICEF, 2007). Successes such as this one by UNICEF are often touted to show progress: "The global rate to be reached by 2015 is 31 per 1,000 live births, and more than 60 per cent of countries have already reduced child mortality to this level." The progress that this statement seems to signify only highlights the disparity between health in the LDCs and the rest of the world. By region, East Asia and the Pacific, Latin America and the Caribbean, and Central and Eastern Europe are the areas that have reduced child mortality rates to this level. This still leaves every region of Africa as well as South Asia, the areas containing the majority of LDCs, at much higher risk for child mortality and not on track to meet the goal.

[4] The under-five mortality rate is the probability (expressed as a rate per 1,000 live births) of a child born in a specified year dying before reaching the age of five.

The other indicators for this goal also show the unequal disparity between regions for attaining a reduction in child mortality. Infant mortality has reduced from 64 to 49 between 1990 and 2006 as compared to 113 to 90 in the LDCs. Once again, substantial declines were only seen in the regions previously mentioned as successful, leaving the LDCs lagging behind. The last indicator, immunization, is one of the most cost-effective public health tools. While sub-Saharan Africa and South Asia continue to lag in this area of health as well, it is the indicator in which they are most on par to reach the rest of the world, with worldwide coverage at 79 per cent and sub-Saharan Africa and South Asia at 72 and 63 per cent respectively. While a small number of the LDCs are on track to meet these child mortality goals, there are still considerable disparities between urban and rural areas as well as between boys and girls (UN, 2003).

Improve Maternal Health: According to the main target of this goal, the maternal mortality rate[5] should be reduced by three-fourths between 1990 and 2015. Maternal mortality is especially difficult to measure because where levels are the highest, they are least likely to be reported correctly. They are also fairly rare events, even in the areas where it occurs most often which leads to errors in measurement. The world total for maternal mortality has decreased from 430 deaths per 100,000 in 1990 to 400 in 2005. This decrease is minimal in comparison to that which is needed to reach the goal. More importantly, the maternal mortality rate for LDCs is currently 870, more than double that of the world total. Of the estimated total of 546, 000 maternal deaths worldwide, developing countries accounted for 99 per cent of the deaths, with more than half coming from sub-Saharan Africa and more than one-third coming from South Asia (WHO, 2007). The other indicator for improved maternal health, proportion of births

[5] The maternal mortality rate is the probability (expressed as a rate per 100,000 births) of a woman dying while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

attended by a skilled health personnel, is considered to be the main factor in lowering maternal mortality and newborn deaths. Approximately 63 per cent of births worldwide are attended by skilled health personnel, with the LDCs once again trailing with only 38 per cent.

Combat HIV/AIDS, Malaria, and Other Diseases: Attempting to analyze the collective progress, or lack of progress, for diseases such as HIV/AIDS and Malaria is a difficult task in itself and beyond the scope of this paper. It is well known that the burden of disease in terms of HIV/AIDS and malaria is highest in LDCs. Malaria for example is endemic to 107 countries and territories in tropical and sub-tropical regions, affecting sub-Saharan Africa most severely. HIV/AIDS and malaria have separate and extensive programs designated to address more specific goals related to these diseases. Progress is measured not only in terms of decrease in overall cases of HIV/AIDS or malaria, but also activities such as providing malaria nets, increasing condom use, or providing drugs for treatment. While substantial foreign assistance and worldwide attention has been focused on the area of disease in the LDCs, the organizations in charge of allocating the aid admit to the underwhelming progress in these areas as well. Both HIV/AIDS and malaria remain consistently higher in the LDCs despite reductions of the diseases in other areas.

Looking collectively at the three main goals related to health it is apparent that a focus on the poorest regions is necessary for reaching the MDGS. The poorest countries, even among the LDCs, are at the highest risk for not meeting these goals. By creating the MDGs, the worldwide community pledged to address and improve the health care needs of the poor. However, the current status of the goals shows that donor support and dedication to the goals is lacking. The following table summarizes the current status (as of 2007) for each health goal according to region. It highlights the discrepancies in health care, showing the worst conditions in sub-

Saharan Africa and Southern Asia. Every target in sub-Saharan Africa has shown "no progress, or a deterioration or reversal." Every target in Southern Asia is "not expected to be met by 2015" (UN, 2007).

Table 3.3 MDGs Progress Chart 2007

*Region**	*Reduce Child Mortality*	*Improve Maternal Health*	*Halt and reverse HIV/AIDS*	*Halt and reverse malaria*	*Halt and reverse tuberculosis*
Northern Africa	Low mortality	Moderate mortality	Low prevalence	Low risk	Low mortality
Sub-Saharan Africa	Very high mortality	Very high mortality	Very high prevalence	High risk	High mortality
Eastern Asia	Low mortality	Low mortality	Low prevalence	Moderate risk	Moderate mortality
South-Eastern Asia	Moderate mortality	High mortality	Low prevalence	Moderate risk	Moderate mortality
Southern Asia	High mortality	Very high mortality	Moderate prevalence	Moderate risk	Moderate mortality
Western Asia	Moderate mortality	Moderate mortality	Low prevalence	Low risk	Low mortality
Oceania	Moderate mortality	High mortality	Moderate prevalence	Low risk	Moderate mortality
Latin America & Caribbean	Low mortality	Moderate mortality	Moderate prevalence	Moderate risk	Low mortality
Commonwealth of Independent States: Europe	Low mortality	Low mortality	Moderate prevalence	Low risk	Moderate mortality
Commonwealth of Independent States: Asia	Moderate mortality	Low mortality	Low prevalence	Low risk	Moderate mortality

Source: Millennium Development Goals: 2007 Progress Chart, UN

* Countries experiences in each region may differ significantly from the regional average

There is an obvious and undeniable connection between all of these health goals. Improving any area of health would lead to improvement in the other areas. Also, looking at the progress of the health goals collectively it is clear that successes are minimal in comparison to the overall progress expected to reach the MDGs. It is also important to recognize that the regions with the majority of the health problems specified are showing the least progress in terms of meeting the goals. Areas with the worst quality of health have the potential to show the greatest amount of improvement, yet that has obviously not been the case so far. Of course health factors are not the only consideration for LDCs. Among the many approaches to development, having a healthy population is one of the leading factors for success.

Currently, the literature on foreign assistance to health is dominated by research concerning communicable diseases, and HIV/AIDS more specifically. Not to undermine the importance of this area of health research, other more basic factors associated with health are crucial to the development of countries receiving aid. Also, research in the field of development assistance is often presented by multinational organizations involved in the disbursement of aid, such as the WHO, the UN, and OECD to name a few. While these are undoubtedly the reliable sources for data, it is worth questioning and further examining the internal analysis they have provided for the effectiveness of the aid allocation. Secondly, this thesis will use a qualitative approach to specifically examine the motives and outcomes of aid that is allocated to the health sector. While it is necessary to rely on data for this analysis, traditional statistical methods will not be used. A multitude of statistical analysis has been carried out on this topic. Yet, it appears that previous research has not successfully addressed the underlying reasoning behind the lack of effectiveness in specific areas of development assistance, specifically the health sector. It is not the purpose of this thesis to empirically test the models discussed which would certainly require

extensive data collection. Rather, this purpose of this thesis is to serve as analytical tool for understanding the effects of the institutions on donor allocation to the recipient countries. The following chapter will use the relevant political science literature to analyze the hypothesis in terms of the institutional effects on donor interests and recipient needs.

CHAPTER 4

FINDINGS

This chapter will provide the analysis of the hypothesis as it is related to the inefficiencies in aid associated with both donors and recipients. The hypothesis is based on policy assumptions associated with foreign aid, how it has been allocated to health, and the effects of that aid on health care goals. The donor interest and recipient need aspects each represents an aspect of the current problem with health care and foreign aid. The first explanatory variable of the hypothesis is related to the donor interests and specifically how those interests do not align with long-term goals. The second explanatory variable in the hypothesis will focus on the needs of the recipients as they relate to the funds that are distributed. Lastly, both variables will be considered more broadly in an agency theory framework in order to analyze the relationship between the variables.

Donor Interests

In the assumption that there is a disconnect between donor interests and recipients needs, it is often argued that donor interests in the area of health care are shortsighted. Keeping in mind that donors interests have been empirically shown to be focused on the political and strategic welfare of the donor, this would be concurrent with the idea that the needs of the recipients are not the first consideration.[1] This propensity to try and achieve short-term goals is directly in

[1] See Maizels and Nissanke (1984), McKinlay and Little (1977, 1978, 1979) and Trumbull and Wall (1994) for analyses of the determinants of foreign aid using cross-country regressions.

contrast to what is needed in order to stabilize and attempt to improve health care. This section will seek to analyze the interests of donors as well as the assumption that their goals are indeed too shortsighted to produce successful attainment of the MDGs related to health. This section will initially discuss the broad interests of donors and the transition to interests focused on the social infrastructure of developing countries, specifically in the health sector. Then this section will consider the need for immediate results and inconsistencies in policies as possible reasons donors pursue short-term goals.

There are a variety of interests that exist among donors. Not only are there differences between the agendas of bilateral and multilateral donors but also between bilateral country donors and multilateral agencies. Despite the multitude of possible interests there are distinct trends concerning why aid is allocated. In a quantitative analysis conducted by Maizels and Nissanke (1984), they found that aid given by bilateral donors is given for political, security, and trade interests, which is consistent with the donor interest model and multilateral aid is given to compensate for resources in the recipient country, which is consistent with the recipient need model. However, simply because the donor interest model generally supports bilateral aid does not mean that poverty reduction is not a goal of bilateral donors. However, because it is more efficient for multilateral agencies to pool resources, they are thought to have interests focused more strongly on poverty reduction (Amegashie, 2007). This function of multilateral donors is a central reason bilateral donors also donate to multilateral organizations. It allows for bilateral donors to keep their preferences concerning strategic interests in mind while still acting to achieve common goals such as improvement in health care. Therefore, there is a consensus that multilateral aid is generally given in order to address an existing problem in the recipient country, in this case health care in LDCs. However, going beyond quantitative analysis, the

interests of bilateral donors are not solely confined to strategic policy interests, but share the goal consistent with multilateral agencies.

Collectively, the way in which bilateral and multilateral donors have chosen to distribute development aid has also changed over time to favor a method that focuses strongly on social infrastructure such as health care (also including sectors such as education, water supply, and sanitation). Initially, in the 1950s, GNP growth was used as the yardstick of development and there was a strong faith in the ability of the recipient governments to use the aid efficiently to trigger economic growth. In the 1970s the primary objective of foreign assistance became raising the standard of living for the poor through increased employment. During the debt crisis of the 1980s there was a sentiment to reduce aid and let private capital flows act as a substitute. Only beginning in the 1990s have aid flows significantly shifted to social infrastructure such as health care and away from productive sectors such as agriculture and industry with poverty alleviation and improvement in human rights as the objective of development assistance (Tarp, 2000). During this time, even within the area of social infrastructure, special attention has turned to the health sector for the various reasons this thesis has previously discussed such as an increased interest in human rights and the fear of global health and security. With the conclusion that both multilateral and bilateral donors have concentrated their goals and interests on poverty reduction through improving social infrastructure, a closer look at specific policy for health care is necessary.

Humanitarian causes have become widely known as a result of globalization and especially coverage and attention from the media. Health in LDCs (with a focus specifically on sub-Saharan Africa) is debatably one of the most well-known human rights crises currently in the world. This knowledge of the health situation has prompted the public in developed countries to

advocate specific policies directed at singular issues, such as HIV/AIDS treatment, without complete consideration of the larger concern of health care. In reference to the increasing amount of aid allocated to human rights projects, Riddell (p330, 1999) identifies "the valid criticism that too much money has often been allocated to short-term projects without sufficient attention being paid to ways in which more deep-seated structural problems need to be addressed." Humanitarian interests in health are too narrowly focused to have an impact on the larger health situation.

Not only do funds often become focused on one specific area of health but also individual countries rather than entire regions. The HIV/AIDS epidemic in sub-Saharan Africa has gained the most attention worldwide. Current trends towards health care in Africa have disproportionally favored aid to this area over other diseases and basic health care. Among other "popular" issues on health agendas have become malaria and malnutrition. While they are both serious components of the health problem in LDCs, addressing only specific issues such as these will not improve overall health. Even small successes in an individual area can be touted as improvement for the donor country. "Donors engage in these practices to increase the visibility of their efforts and the short-term appearance of success for their individual projects, at the expense of coherent policy making and capacity building in the recipient country's public sector" (Knack p178, 2007). Without a comprehensive policy toward health care, addressing specific issues is unlikely to make a significant impact.

The appearance of success with health aid and health policies is important because bilateral donor countries are held responsible to the general public within the country. According to Buse and Walt, "…As a function of their annual accountability to constituencies at home, bilateral agencies face pressures to demonstrate results, preferably quick and measurable ones"

(Buse and Walt p.451, 1997). As globalization has increased knowledge of how money is spent on foreign affairs, the public expects results from the aid that is given by their government. In the area of health care, this often results in policies and allocation that can be measured easily and results that can been seen quickly. Therefore, in addition to the political and strategic concerns of bilateral donors, they must also consider the interests of the public. This domestic pressure is partly to blame for decreases in overall ODA. However, even as aid to health remains relatively high compared to other sectors, domestic pressure remains one of the guiding forces behind which policies bilateral donors favor (Walt, 1999).

Multilateral donors do not face the same pressure as bilateral donors to produce results that please the public. They are not expected to the have the immediate results that bilateral donors often held to by the public. This serves as justification for multilateral donors to invest in long-term projects most often and have a stronger focus on recipient needs in comparison to bilateral donors. However, in the case of ODA to the health sector, both bilateral and multilateral donors tend to allocate funds in similar proportions to similar areas. While the total allocations from the bilateral donors is significantly higher than those from the multilateral donors, the areas of interest in the health sector appear to be fairly consistent with a few minor exceptions.[2] This fact refutes the claim that bilateral donors share more of the blame for the ineffectiveness of aid in the health sector. While bilateral donors do contribute more in real dollars, multilateral donors appear to have no more consistency with their expenditures or focus on long-term goals. The following table shows the multilateral and bilateral allocations for to each specific sub-sector of health from 1990 to 2005 in constant 2005 US$.

[2] According to the OECD, bilateral and multilateral assistance broadly has the same emphasis with both focusing the largest proportion on HIV/AIDS and other STD control. In the past, health and policy management received a greater proportion of multilateral funding, but that trend has diminished (OECD and WHO, 2003)

Table 4.1 Bilateral and multilateral foreign aid to the health sector

	1990-1991	*1992-1993*	*1994-1995*	*1996-1997*	*1998-1999*	*2000-2001*	*2002-2003*	*2004-2005*
Health policy & admin management	B 437.7	339.4	313.8	440.4	615.3	279.1	420	710.7
	M 555.9	252.7	327.2	224.3	866.5	378.1	277.3	346.7
Medical education & training	B 17.5	4.7	1.2	5.6	25	121.4	30.1	59.6
	M 0	0	0	0	0	0.1	0	0
Medical research	B 3.2	1.0	8.5	1.8	15.1	14.4	12.8	71.9
	M 0.7	0.1	0.1	0	0	0	0	0
Medical services	B 42.8	84.7	73.6	149.9	152	123.5	151	93.8
	M 0.1	1.8	0.2	32.2	0.1	24.4	13.4	165.0
Basic health care	B 42.6	79.2	274.2	219.6	185	456.8	636.1	724.3
	M 0	23.9	49.3	137.3	114.8	282	232	402.4
Basic health infrastructure	B 72	136	95.9	68.5	155.6	143.1	99.8	146.1
	M 27.5	86.7	49.2	12.9	50.5	15.7	16.3	10.2
Basic nutrition	B 5.6	19	49.3	9.3	29.8	65.8	40.9	43.2
	M 0	35.7	84	0	82.1	127.1	37.1	316.1
Infectious disease control	B 36.7	50.5	84.5	131.9	173.7	218.3	234.5	268.6
	M 37.9	1.4	15.3	18.1	0.1	23.8	218.7	668.9
Health education	B 10. 8	18.9	25.3	15.1	29.8	27	29.1	25.1
	M 0	25.7	34.8	2.2	0	4.5	12.7	9.0
Malaria control	B 0	0	0	0	0	0	0	16.6
	M 0	0	0	0	0	0	0	222.9
Tuberculosis control	B 0	0	0	0	0	0	0	1.4
	M 0	0	0	0	0	0	0	120.3
Health & personal development	B 14.7	23.9	1.7	14.6	16.9	22.9	24.7	26.4
	M 0	3.9	0	0.2	0	24.1	0	6.8
Population policy & admin. management	B 24.2	60.7	35.4	88.6	85.5	48.6	222.1	136.3
	25.6	21.4	22	9.2	13.2	107.9	102.2	27.2
Reproductive health care	B 77.8	141.7	105.8	114.3	166.4	103.9	118.7	149.1
	M 15.9	0	22.1	0.3	36.5	42.1	140.1	33.1
Family planning	B 171.6	312.1	192.3	122.7	292.3	232.9	97.9	63.9
	M 65.4	19.1	29.4	0	0	45.8	57	2.8
STD control including HIV/AIDS	B 62.3	65.1	122.2	93.5	158.6	382.9	758.5	1399.4
	M 0	7.8	111	1.1	45.1	368.4	1043	816.7
Personal development: population health	B 0	0	0	0	0	0.3	1.2	1.0
	M 0	0	0	0	0	0	0	0

Source: CRS online Database on aid activities

Despite the fact that bilateral and multilateral donors interests coincide on a general basis, this has not lead to coordinated efforts or effective policies. Two reasons for this ineffectiveness can be identified. First, despite the collaborative effort to fund the same general areas, they are not necessarily the areas that will produce the most progress toward the health goals. This issue will be further discussed in the recipient needs section of this paper. The second problem is that concentrated aid to general areas does not ensure consistent policies. Case studies of specific countries show that even within narrowly defined sub-sectors of health donors often support different forms of treatment for diseases, establish parallel policies that do not overlap, and exacerbate inequalities in health access such as those between urban and rural regions, among other problems (Fryatt, 1995; Walt, 1994; Kanji, 1992; Pavignani & Durão, 1997). This shows that even if a majority of donors can reach a consensus on which areas of health to address, it does not mean it will be well coordinated or effective.

The inconsistencies in aid to the health sector multiply when one considers how often even the policies of one bilateral donor can change. By focusing on the U.S. alone, it is obvious that events such as the change of presidential administrations could vastly change the focus of foreign aid policies for health. The desire for individual politicians to focus on short-term policy is in line with the concept previously discussed concerning the benefits of these types of policies. By focusing on short-term health goals, individual politicians have the potential display his or her successes to the public, whereas the benefits of aid of long-term health goals would only be seen in a lag much later. Another effect of different presidential administrations is the differing and often inconsistent policies enacted for foreign aid disbursement. For example a president's ideological or political agenda can effect the disbursement of aid to the health sub-sectors. When assessing the time frame from 1990 to 2006, one major sub-sector of health was affected more

than the others by the change in administrations: STD control including HIV/AIDS. The following figures show the changes in the sub-sector from 1990 to 2006 in terms of constant USD in 2005.

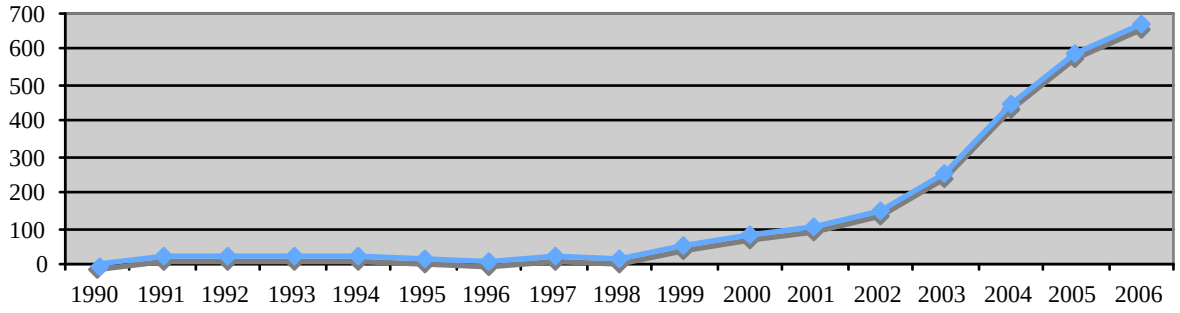

Figure 4.1 U.S. Aid to sub-sector HIV/AIDS

The other sub-sectors fluctuated but did not produce the significant jump in funding seen for HIV/AIDS. President Bush clearly concentrated U.S. ODA to health on the specific issue of HIV/AIDS with the President's Emergency Program for AIDS Relief (PEPFAR). Beginning with the first year Bush allocated aid in 2002, increases in aid to this sector have been growing exponentially. While some praised this effort others identified the possible religious or moral aspect of the aid allocation, identifying the policies enacted to promote abstinence programs rather than condom use in LDCs. Sharp swings in the allocation of aid to different areas within the health sector and vastly different policies concerning how that aid should be used create an inability to enact a stable health care policy within the recipient country.

Concerning the primary hypothesis, the assumption that donor interests are too shortsighted in comparison to recipient needs is confirmed according to the literature. From a bilateral donor perspective, there is a broad consensus that donor interests do inhibit the long-term improvement in the health sector. Volatile donor interests as well as the desire to see immediate results from foreign aid contributions run counter to achievement of long-term health goals. However, according to the literature, multilateral donors do not face the same pressure to protect political and strategic interests or the pressure to produce immediate results that bilateral donors face. While it is generally agreed that this allows the multilateral donors to focus more attention on long term, basic health goals rather than short-term, policy specific goals it is not confirmed by this data. While it is an interesting topic for future research, this thesis does not seek to answer why multilateral goals for the health sector may be different than what is generally assumed for their foreign aid goals. However, the collective effects of both bilateral and multilateral donor uncoordinated and short-term interests will be discussed later.

Recipient Needs

The ineffectiveness of aid to the health sector is also attributed to the fact that the recipient countries' health care needs are more extensive than can be addressed with the current foreign aid policies. Two current problems can be attributed to the inability of LDCs to reach the health goals. The first problem, which is a lack of sufficient funds, must be addressed before there is any hope of reaching the goals. Simply because aid to the health sector has continued to increase despite the drops in overall ODA, this does not mean that it will be enough to achieve the goals. Secondly, aid to the health sector is not allocated to the programs that would have the most widespread benefits. Without focusing on the basic health care needs and pro-poor policies,

the goals are unlikely to be met. This section will elaborate on the current literature in the field concerning both problems.

One crucial factor, the lack of adequate funding, continues to prevent attainment of the health goals. There is a consensus that overall ODA and ODA to health must be dramatically increased. A disparity between the required and committed aid to health has existed since the formulation of ODA. The development of the MDGs was expected to focus attention and financial resources on health concerns. Yet the creation of the MDGs has had no observable influence on closing this gap. According to the Commission on Macroeconomics and Health report in 2001, donor spending on health would need to be $14 billion by 2007 and $21 billion by 2015 for the LDCs in order to reach health goals. As of the most recent data available (2006), total spending for health in the LDCs was $4.247 billion. Even though health spending has been steadily increasing, it can be assumed that the actual spending in 2007 was less than half of what would be necessary in order to be on track for reaching the goals. According to Shiffman (p. 419, 2006), “Even diseases that appear to be prioritized receive amounts that are far from adequate.” This indicates that even specific diseases that receive comparatively large amounts of aid such as HIV/AIDS are in need of an increase. Of course all areas of ODA would require an increase in aid to sustain successes in any one area. Other areas of social infrastructure have experienced similar problems as that of the health care sector in that funding has been on the increase but not at a fast enough rate to meet goals. To meet the MDGs for health it would require substantially larger allocations from donors. However, to put the needed ODA increase in perspective, it would only require about 0.1 percent of total donor GNP.

The issue of increasing ODA raises a controversially point concerning the stability of the recipient countries. While it is necessary to increase the amount to the health sector in order to

reach the goals, a massive increase from one year to the next would no doubt lead to further problems for already unstable economies. Slowly phasing in increases in aid is the best approach because it will ensure that the resources are used both effectively and honestly. Large, immediate increases would cause problems with monitoring the disbursements as well as monitoring the success and progress of the policies enacted. However, the goal date of 2015 is quickly approaching. The desire to reach the goals by 2015 runs counter to the strategy for implementing a progressive increase in aid over time. Had a more effective strategy for increasing aid been implemented from the outset of the goals, the possibility of reaching the 2015 date would be more feasible. However, as of 2008 with only seven years remaining to reach the goals, the type of incremental increases in aid needed are no longer plausible. This situation suggests serious improbabilities for the reaching the MDGs.

Despite the under funding in aid to the health sector, it is still important to consider the way in which aid is allocated to the recipient countries. According to the World Bank (1998), the allocation of foreign aid would have the greatest impact on reducing poverty if it were targeted to the poorest countries with the best institutions and policies currently in place. In general aid donors, both bilateral and multilateral, have begun to adhere to this policy. This is generally considered positive news for development aid with two major exceptions. The largest donors of aid are among the least selective when it comes to focusing aid on poverty alleviation.[3] Therefore, focusing aid on improving health care in LDCs will continue to be a problem until these major donors begin to adhere to the same polices as the others. Secondly, as donor countries tend to adhere to the policy of focusing aid on the poorest countries with the best

[3] According to a report to the World Bank, France, the U.S., Japan, and the European Commission are four of the largest donors yet they do not generally focus on areas with the most poverty. In order for development assistance to work in impoverished countries these donors must provide aid to reinforce what is being given by the other donors (Dollar, 2006).

existing institutions and policies in place, they are excluding many of the countries that need health aid the most. By denying adequate health aid, this policy virtually eliminates the possibility of poorly performing countries and failed states to improve the current health situations. Studies have shown that a good policy environment was necessary in order for aid to have a positive effect (Gwin, 1997; Burnside and Dollar, 1996). However, a good policy environment requires a functioning civil society and a population that believes in the legitimacy o f their institutions. These qualities are unlikely to be present in countries with the worst health care situations where aid is most needed.

As has been previously acknowledged, enough ODA to health is not being provided in order to reach the goals. Assuming that aid is not dramatically increased, prioritizing health concerns is of vital importance. The health care needs within a recipient country are constantly being analyzed in order to determine how to allocate the scarce funds to the variety of concerns. Priority setting is an unfortunate reality when allocating aid. However, the disability adjusted life years (DALYs)[4] index was created specifically in order to address the issue of scarce resources to the health sector. This index expresses the years lost to a given disease in order to monitor the overall burden of disease (Michaud, 2001). This index has been used to compare the burden of disease within a country to the amount of aid given for specific health initiatives.

Shiffman (2006) conducted a study specifically targeted at aid to communicable diseases in the developing world.[5] He found that donors did not allocate funds in accordance with the needs of the recipients. When analyzing the burden of disease, as determined by the DALYs, he

[4] One DALY represents a single lost year of healthy life, and the sum of DALYs lost to all causes can be interpreted as the gap between the actual health situation and an ideal world in which everyone lives disease and disability free to advanced age. DALYs lost to a given disease category divided by total DALYs lost is a measure of the importance of that disease category relative to all diseases combined (MacKellar, 2005).

[5] Shiffman uses a similar framework in that he also considers bilateral donors who are members of the DAC as well as multilateral donors also considered in this study.

found evidence that ODA to health did not correspond with needs. An example of the inequity he found is the comparison between HIV/AIDS and acute respiratory infections. Among the diseases he chose, HIV/AIDS represented 31% of the disease burden while acute respiratory infections represented 26%, which represented the first and second highest rates. Considering the two diseases share a similar percentage of the disease burden, HIV/AIDS receives 46% of the donor funds while acute respiratory infections in comparison receive about 2.5% of donor funds. It is worth noting that other diseases such as polio and leprosy also receive a relatively high amounts of donor funding compared to the burden of disease they represent. However, this can be attributed to those diseases being singled out for eradication. Ultimately, Shiffman determined that recipient needs in within the specific area of communicable diseases were not the primary factor in determining donor allocation.

MacKellar (2005) also analyzes DALYs and finds HIV/AIDS receives a larger proportion of aid than is represented by the burden of disease. He considers not only infectious diseases, but all forms of disease defined by the WHO. STDs including HIV/AIDS accounts for 5.8% of the burden of disease and receives 28.5% of the funding to the health sector as of 2001. In comparison, all other infectious diseases account for 23.6% of the burden of disease and receive 20.8% of the aid allocated to the health sector. This reaffirms that aid to the health care sector is not allocated in a way that directly coincides with burden of disease within the recipient countries. MacKellar concurs with Shiffman's findings that the burden of disease in the recipient countries is not the primary priority when allocating aid.

When comparing the burden of disease and the amount of donor funding to the health sector, it is clear that specific concerns such as HIV/AIDS receive a disproportionate amount of the funding. Aid allocation cannot be contributed directly to the burden of disease within the

recipient country therefore other factors associated with the donor countries must play a major role. Shiffman attributes inequalities between disease burdens and donor allocations to the rapid spread of certain diseases as well as dynamics that exist in the donor countries. These dynamics include the idea that specific diseases cause a national security threat to the donor countries and the possibility of interest groups mobilizing around certain diseases to bring attention and funding to those areas of the health sector. Diseases and health concerns that are generally concentrated in the LDCs or that are treatable in the donor countries tend to receive smaller allocations compared to the burden of disease they represent in the recipient countries.

While HIV/AIDS does receive a disproportional amount of the funding within the health sector, some experts on public health believe it is the primary concern and even more emphasis should be focused on the epidemic. While the statistics associated with HIV/AIDS do show astonishingly high rates, it is by no means the singular health concern for LDCs. A comprehensive approach to the health care sector would obviously include a serious component to address this particular health concern. However, a comprehensive approach must also focus on basic health care concerns that impact the entire population.

Further evidence of the disease-specific allocation of funds is apparent with the emergence of the various public-private partnership initiatives such as PEPFAR, Global Fund for AIDS, Tuberculosis, and Malaria, and the International AIDS Vaccine Initiative to name a few. The funds for the initiatives come from the traditional resources of both bilateral donor countries and multilateral aid agencies. As these initiatives gain more funding they are subsequently taking funds from other health care concerns due to the scarce resources available (MacKellar, 2005). These disease-specific initiatives, known as vertical control initiatives, are in conflict with the horizontal reform approach that is necessary in order to address long-term goals in LDCs and

improve the health sector (Shiffman, 2006). As horizontal reforms to the health care sectors in the LCDs are touted, their progress is likely to continue to be stifled by the persistent creation of disease-specific initiatives.

Investing in long-term goals is not only beneficial for the recipient country, but also the donor countries as well. Immunization coverage is an example of the need for long-term health goals. For the recipient country, as immunization coverage increases, the non-immunized will be better protected as well, potentially leading to possible eradication of the disease such as occurred with smallpox. Annually, hundreds of millions of dollars are saved on routine smallpox immunizations that are no longer necessary. “To achieve these savings, every case of smallpox had to be eliminated, which in turn depended on mass immunization of the poorest of the poor, which in turn required investments by the richer countries” (Sachs p. 29, 2001). Measures aimed at complete eradication of a disease can improve nearly all aspects of broader health within an area such as child and maternal mortality rates. These small successes also allow for aid to the health car sector to be directed at other important areas. This would also require a relatively small amount of aid to eradicate one disease through immunization as opposed to the amount of aid that is focused on projects such as HIV/AIDS. Therefore, the fairly small costs would produce large benefits for the recipients in terms of eradication of a diseases and a broad decrease in factors such as mortality.

Organizations that focus on poverty reduction have stated that most effective approach to meeting recipients’ needs would be a stronger focus on pro-poor health. This approach is intended to strengthen the health sector within the recipient countries in an attempt to address the problems the recipients find most important. It is also intended to provide countries with a means for better utilizing the donor aid that is provided to the sector. A pro-poor approach is one that

gives priority to promoting, protecting, and improving the health of the poor. It also includes the development of pro-poor health systems, with equitable financing mechanisms. Also, it encompasses policies in areas that disproportionately affect the health of the poor (OECD, 2003). However, this pro-poor approach still leaves countries with weak policies and institutions under-financed for the health care sector. The OECD refers to these countries as "difficult partnerships." Aid to health in these partnerships is clearly not focused on the immediate recipient needs in terms of health care. Rather, aid is focused on improving health care systems within the recipient countries. Assuming that this approach influences recipient countries to improve their internal health systems, this could be a long-term beneficial investment.

Despite touting the need for an approach focused on pro-poor health, many sub-sectors considered pro-poor are losing their share of ODA to health with the notable exception of HIV/AIDS. The OECD has identified the following sub-sectors as pro-poor: basic health infrastructure and care, health education an personnel development, basic nutrition, infectious disease control excluding HIV/AIDS, reproductive health and family planning, and STDs including HIV/AIDS. The following table identifies these pro-poor health sub-sectors as a share of total ODA and as a share of the total ODA to the health sector. This table shows that aid to the pro-poor health sectors has mainly been concentrated in the sub-sector of STDs including HIV/AIDS while other sub-sectors have not shown growth or in some cases declined. Basic health care has also experienced a sizeable increase yet the aid to HIV/AIDS has still increased at twice the rate of basic health care. This rhetoric associated with encouraging pro-poor health initiatives yet not providing aid to all the sub-sectors where it would be beneficial displays a lack of coordination between goals and commitments from the donors.

Table 4.2 Pro-poor health sub-sector shares (%) to the LDCs, 1990 and 2006

Health sub-sector	*Share of aid for*			
	All ODA		Health ODA	
	1990	2006	1990	2006
Basic health care	0.1	2.4	2.6	17.6
Basic health infrastructure	0.3	0.2	8.6	1.4
Health education	0.0	0.0	0.2	0.2
Health personnel development	0.0	0.0	0.9	0.2
Basic nutrition	0.0	0.2	0.5	1.3
Infectious disease control	0.3	0.8	7.8	5.5
Reproductive health	0.2	0.7	5.8	5.1
Family planning	0.5	0.1	12.4	1.0
STDs including HIV/AIDS	0.1	4.8	2.8	34.9
Total pro-poor health sub-sectors	1.6	9.2	41.7	67.2

Source: CRS online database of aid activity

Returning to the primary hypothesis, the literature and data clearly show a disconnect between the needs of the recipients and the allocation of donor funds. The data concerning the investment in pro-poor health also shows that donors are not focusing on the sub-sectors of health that have been designated as pro-poor. In order to reach the MDGs the pro-poor areas of health are in need of the most funding. However, aid to the health sector has been focused on disease-specific initiatives, which do not benefit the long-term health goals of the LDCs. Additionally, in accordance with more broad-based approaches to improving the health sector, donor aid must increase dramatically in order to reach health goals.

Coordination and Information in the Donor and Recipient Relationship

The role of institutions in the aid allocation process can be signified as the primary factor in performance of foreign aid. As the previous discussion of donor interests and recipient needs outlined, ineffectiveness can be attributed to institutional factors and specifically the lack of

coordination between the organizations involved.[6] One of the first studies to address institutional factors in aid allocation was Quarles (1988) who summarized this approach to aid delivery:

> Aid agencies are not just rational, neutral tools of policy makers and as such external to the problems of development…Special attention is given to the linkages or relationships between development agencies at different levels of organization. Each one is part of increasingly long and complex chains of interdependent organizations. The other units constitute a vital part of its environment. These linkages, therefore, are a major concern in the contributions. In a sense, all development organizations are intermediate bodies, part of wider network through which the money flows. (Quarles et al. p. 12, 1988)

This highlights the complexity associated with organizations and institutional norms in the aid delivery chain and briefly touches on the reasons behind ineffectiveness. The literature on agency theory can provide insight into the role of institutions in aid effectiveness. Three aspects of agency theory can be identified that link institutions to ineffectiveness. These aspects are the fact that multiple principals and objectives exist; there is a broken information feedback loop; and lastly the institutional reform dimension of current foreign aid allocations (Martens, 2002). These aspects of agency theory can be applied to the current situation with aid to the health sector in LDCs. All of these factors can be attributed to imperfect information flows in the aid allocation process.

Multiple principals (donor countries and donor agencies) share a vaguely defined objective (meet the MDGs for health) but enact a variety of policies concerning the details of reaching the goals. Even though aid organizations have identified the MDGs as a collective objective, inconsistencies in underlying objectives still hinder the process of reaching the goals. Complicating matters, the agents (recipient countries) cannot use the aid effectively because of

[6] Institutions and organizations are distinct entities. Organizations consist of the groups of people that participate in aid allocation including taxpayers, donor organizations, politicians, donor agencies, and recipient organizations. Institutions serve as the formal and informal rules and behaviors that affect the performance of aid.

the inconsistencies and contradictions between the multiple donors. This aspect of agency theory coincides with the conflicting donor interests discussed earlier.

The broken information feedback loop is an example of the inability of aid to address the recipient needs. With foreign aid there is a political and geographical separation between the recipients and the donors which inhibits information sharing. For donors there are increased costs associated with obtaining reliable information about the recipients' views of the aid allocation and programs that are enacted. This can be attributed to the fact that recipients are not likely to share the same preferences as the donors or necessarily measure success in the same way. Also, there are logistical problems associated with obtaining information concerning the recipients' view of the aid in the LDCs. Often indirect assessment of aid allocation and effectiveness are a substitute for the direct opinions and views of the recipients.

Lastly, there has been a push by those who analyze foreign aid to move toward institutional reforms of the health sector within the recipient countries. Studies have consistently shown that the improvement of the health sector as whole, through broad-based initiatives and improvements in infrastructure and health education, produces an environment for aid to be more effective. However, it is clear that donors tend to favor disease-specific policies that are more likely to produce tangible outcomes that can be measured and verified. Institutional reform that is necessary would have more diffuse outcomes and successes would be more difficult to verify (Martens, 2002). This paradox of needing to introduce institutional reforms with donors focus on specific health care policies in a major contributing factor to ineffectiveness. The remainder of this section will address how the lack of information and coordination ingrained in the institutions has caused aid inefficiency and the measures that are being taken to address these problems.

In order to address the donor-recipient information problem, the DAC has made a commitment to increase transparency between members and within the organization. They have two ways that allow for members to monitor the effectiveness of their aid and support their common goals along with simply tracking ODA commitments and disbursements. First, they undertake peer reviews to monitor individual members' policies and programs as well as assess their effectiveness against their stated goals. Secondly, it provides a common guidance on a range of issues to make aid more effective such as providing categorized groups for health care (Faure, 2002). These measures are intended to increase the information between the different donor members involved has well how the aid is being used for common goals. However, these measures do not address the aspect of the feedback loop concerning the recipients. Without increased communication and information between donors and recipients, inefficiencies are likely to continue.

The DAC has also been focused attention on the coordination of goals among members. All ODA either addresses poverty reduction directly or indirectly, but since 2000 the DAC has been working to link aid more directly to the targets associated with the MDGs (OECD, 2003). This move toward directly focusing aid on these targets will serve to prevent the use of aid on programs that do not address the specific goals. It is assumed that directly focusing aid on the MDGs will increase the effectiveness of the goals. However, the DAC has been working to create this link between the MDGs and the distribution of ODA since 2000 and yet to produce significant progress in most of the LDCs. This can be attributed to the fact that multiple donors may share this overarching goal, yet still have not agreed and coordinated their efforts on the specific path to take in order to reach the goals.

Coordinating the efforts of donors is imperative in making any progress toward the health MDGs. The coordination of efforts and transparency between donors is important to more quickly and efficiently reach the goals. However, not providing more information could actually prove to be detrimental to any success already achieved. “However praiseworthy are the words and intentions of one donor, on their own these words and the potential impact of aid remain comparatively small…Unless the approaches and policies of different aid donors, especially the largest donors, are coordinated, not only will the potential effect of aid be reduced but it is quite possible for the efforts and approaches of one donor to undermine those of another” (Riddell p315, 1999). Inconsistencies between donors concerning aid allocation is one of the primary reasons health goals continue to stagnate or fall further behind in many areas.

In order to see how better coordination would lead to improvement in the health sector, the process as a whole must be considered. It is generally difficult to assess the effectiveness or impact of aid coordination. This requires a broader analysis of the processes, outputs, and outcomes as they relate to the interests associated with the donor-recipient aid relationship. According to case studies by Walt (1999), the processes, outputs, and outcomes vary substantially between countries, which indicates that aid management continues to be dependent on specific contexts rather than applying effective measures more broadly. The following table breaks down inputs, processes, outputs, and outcomes as they relate to aid for the health sector. The table shows that increasing coordination at the outset of the aid disbursement process would inevitably create a domino effect on the processes, outputs, and outcomes. This would then lead to improvements in the entire system as a whole and higher potential for reaching the stated health goals. Coordinating efforts is one way in which the health sector could sustain vast improvements even without substantial increases in funding.

Table 4.3 Inputs, processes, outputs, and outcomes in aid coordination

System component	*Examples of areas of impact on the health sector*
Coordinating aid inputs	• Increase in financial resources available to the health sector • Increase in flexibility with which available financial resources can be used • Increase in skilled personnel working with the sector • Introduction of new ideas and ways of working • Change in overall allocation of resources in the sector
Using aid to strengthen processes	• Reduces duplication of donor activities with each other/with other groups • Increases standardization of staffing, procedures, and information • Supports development of national planning processes and plans • Provides direct contribution to the development of general management systems • Provides direct contribution to the development of systems for monitoring and evaluating health systems
Outputs of improved inputs and processes	• Improved use of available resources, e.g. as reflected in disbursement rates • Strengthened service delivery
Outcomes of improved inputs and processes	• More appropriate patterns of utilization; higher levels of service coverage; lower levels of morality and morbidity (i.e. indicators of good quality system products)

Source: Walt, 1999

Coordination must also occur between the recipient countries. Not all recipient countries are facing the same problems with health care. However, large regions do share general health care concerns. Specific programs have had localized successes and certain LDCs are on track to meet the MDGs. This would require a system to be in place that would share the experiences in one country so that they could be mobilized more broadly. The dissemination of this knowledge

could be the responsibility of the donor agencies. By providing advising and training of successful practices to the recipient countries, the likelihood of success across an entire region would increase. Coordination of aid is would provide beneficial outcomes for both donors and recipients. For recipient governments, improved coordination efforts are a way to ensure that aid is used for the national goals and for donor countries, coordination ensures a more effective use of their resources. Many LDCs face similar health problems. Identifying successful practices in specific countries is an important first step. Then creating a coordinated effort to disseminate those practices in countries with similar problems is a crucial factor in reaching the MDGs worldwide.

Along with the coordination of specific programs, donors and recipients must strengthen their relationships through mutual trust and clear expectations for performance. A new framework for increasing communication between the donors and recipients is currently in place with the Poverty Reduction Strategy Paper (PRSP). These papers are prepared by the recipient countries every three years and outline the country's macroeconomic structure, structural and social policies, and external financing needs. The hope is that PRSPs will create greater coordination between donor financing and country goals. The benefits of the PRSP framework will be a more specific sustainable financing scheme and investment plan for the health sector between donors and recipients (Sachs, 2001). These PRSPs are also an important step in closing the information feedback loop between donors and recipients. With the recipient countries preparing these documents for direct consideration of the donors, there is more complete information in the aid process.

The strain between the donor and recipient relationships can often be attributed to the increasing number and diversity of external agencies. By the early 1990s, there was a noticeable

growth in the number of agencies involved in the health sectors of developing countries. Even though the DAC attempts to coordinate the agendas of the members, the individual donor countries as well as multilateral agencies tend to promote separate and varied policies[7]. According to LaFond, "increased involvement of donors may bring more confusion to the development process, as in Uganda where five national health plans coexist, each supported by a different donor" (LaFond p.190, 1995). With donors providing the majority of funds in LDCs to make improvements in the health care sector, it is imperative to create a coordinated effort to address problems rather than continuing with wasteful and ineffective practices.

The application of agency theory to aid to the health sector properly defines how ineffectiveness has become the norm. Information is incomplete in the aid process. Information not only between the various donors but also between the donors and recipients has led to ineffective policies. Similarly, coordination of policies is inherently difficult with the multiple donors and recipients involved with different agendas and interests. It is clear from the literature that these two institutional changes must be revised in order to create effective health care policies for the LDCs.

Implications

After thoroughly analyzing the previous models of foreign assistance, conclusions can be drawn based on each testable hypothesis:

[7] Bilateral assistance is administered by agencies of donor governments (such as the U.S. Agency for International Development or Japan's Overseas Economic Cooperation Fund). Multilateral assistance is funded by contributions from wealthy countries and administered by agencies, such as the United Nations Development Program and the World Bank. Of all ODA, roughly a third is multilateral (World Bank, 1998).

H1: Foreign assistance allocation based on donor interests increases ineffectiveness in the health sector.

H2: Foreign assistance allocation based on recipient needs increases ineffectiveness in the health sector.

H3: The lack of information and coordination in foreign assistance allocation increases ineffectiveness in the health sector.

H1 was partially supported by these findings. While donor interests do play a role in determining foreign aid, it is not the solitary factor. However, the varied interests of donors and subsequent varied programs they attempt to implement have adversely affected the health sector. Additionally, donors who seek to use aid for short-term successes are impeding progress toward the MDGs.

H2 was not supported by these findings. The needs of recipient countries do not seem to be a primary factor in aid allocation. Allocating aid based on recipient needs would require an overall increase in aid to the health sector and more focused programs concerning pro-poor and broad-based health concerns.

H3 was supported by these findings. Agency theory highlights the needs for information and coordination within the system in order to increase effectiveness of foreign aid to the health sector. A lack of coordination between the multiple bilateral and multilateral donors actions has led to a myriad of non-intersecting policies that do not produce successful results. Additionally, incomplete information between the donors and recipients have led to policies and aid

allocations that are not consistent with the needs of the recipient nor conducive to success for the MDGs.

Considering the previous analysis of the hypotheses collectively suggests two major findings related to the ineffectiveness of health aid. First, the application of agency theory to the health sector provides an insight into the potential reasons aid has yet to be effective. This lack of coordination is a direct result of a lack of information between the recipients and donors. As has been shown, the lack of coordination occurs on every level of the financial aid allocation process. Secondly, this lack of coordination has produced information into an alternative theory of foreign aid allocation. Rather than classifying foreign aid by donor interests or recipient needs, perhaps a more integrated approach of the two models is necessary. A model that accurately describes the relationship between donors and recipients must recognize that decisions are made and outcomes are analyzed in an international context. Therefore, the concept of agency theory and the lack of information present in the foreign aid system reinforce this model.

The new integrated model which Shiffman (2006) refers to as a “global policy” model, is admittedly less parsimonious than the individual donor interest and recipient need models upon which it builds. The benefits main benefit of this model is its explanatory power. The model not only describes how donors allocate aid to the health sector but also provides insight into the focus of this thesis, which is why aid to the health sector is ineffective. While this global policy model has only been considered for the specific sector of aid to health, it is probable that it could be applied more broadly.

The global policy model also provides further insight into the possible reasons behind the ineffectiveness of foreign aid. It posits that aid to the health sector has focused on specific areas of health rather than broad health care concerns or changes in the overall health care system due

to the precedents set by various donors. If a single donor country or agency brings attention to one disease or area of health, it is likely that other donors will adopt similar practices. Since the 1990s funding for communicable disease control as a percentage of total ODA to health rose, including funding for diseases that had been long-neglected such as leprosy, malaria, and the measles (Widdus, 2003). The proliferation of initiatives concerning such diseases cannot be directly attributed to the needs of the recipient countries because many of the diseases had been endemic to the countries long before they received attention from donor countries. Rather, the actions of certain donors may have prompted other donors to provide funds or take an interest in areas they would have otherwise not considered a priority. This model identifies donor allocation to the health sector based on neither the needs of the recipients or even necessarily the interests of individual donors. As donors allocate aid based on precedents set by other donors rather than coordinating their efforts with complete information to meet goals, the priorities established by the donor community will continue to produce ineffective results.

CHAPTER 5

CONCLUSION

"Although health is widely understood to be both a central goal and an important outcome of development, the importance of investing in health to promote economic development and poverty reduction has been much less appreciated. Extending the coverage of crucial health service to the world's poor could save millions of lives each year, reduce poverty, spur economic development, and promote global security."

-- Jeffrey Sachs, November 2001

This thesis has examined the ineffectiveness of foreign aid to the health sector in LDCs. It has considered both donor interests and recipient needs as components of aid allocation and as possible explanations for the lack of improvement to the health care sector. By seeking to find an explanation for this lack of improvement, this thesis analyzed the relevant literature concerning the models and theories associated with foreign policy allocation. This thesis found that both donor interests and recipient needs were taken into consideration, but neither model provided a mutually exclusive explanation of aid allocation or reasoning behind the ineffectiveness of aid. However, after taking into account the lack of coordination and information sharing in all levels of the aid allocation process, a new model was proposed. This model took the concepts associated with agency theory and applied them to foreign aid as it relates to health.

The qualitative data in this thesis provided information that both supported and rejected different aspects of the donor interest and recipient need models. In the health sector aid has yet to produce effective results for either the donor or recipient. By not coordinating efforts between donors and not sharing information between donors and recipients, the health care sector has continued to stagnate or decline in the LDCs rather than make progress. A focused look at the effects of pursuing donor interests or recipient needs in this thesis clearly showed how the lack of coordination and information proved to be detrimental for the health care sectors in the recipient countries and strongly inhibited their ability to reach the MDGs. The hypotheses analyzed in this thesis served as a way to analyze the roles of donors, recipients, and the relationship between these principals and agents in the foreign aid process.

Donor interests are important but in most cases do not align with the overall goal to improve health for the long-term in LDCs. Donors must have vested interest in the success of foreign aid. However, the donor interests are currently more focused on achieving short-term goals rather than focusing on long-term goals associated with health and poverty reduction. From a donor interest perspective, there are a wide variety of interests that the multiple donors (both bilateral and multilateral) could be pursuing at any given time. However, the traditional donor interests associated with trade, security, and politics are clearly not the sole interests of the collective group of donors or of any one donor in particular. There is no doubt that a humanitarian component of foreign aid to health exists. However, donor interests also have non-altruistic aspects as well. “The MDGs are partly an expression of humanitarian concern, but they are also an investment in the well-being of the rich countries as well as the poor. The evidence is stark: disease breeds instability in poor countries, which rebounds on the rich countries as well” (Sachs, 2001 p.28). The literature shows that aid to the health care sector will only be effective if

donor interests focused less on short-term achievements and viewed aid to health as a long-term goal focused on security and stability for both the recipient countries and the rest of the world.

Aid to the health care sector can also on be effective when the needs of the recipients become the focus. This thesis has sought to identify the major areas associated with recipient needs that are currently not being met, and conversely leading to the inability to meet health care goals. First of all and most importantly is a needed increase in aid to the health sector. While this thesis has shown that aid to health has been on the rise even as overall ODA declined in the 1990s, it has also been shown that it is still far from enough. Numerous studies have shown that aid to the health sector must be dramatically increased in order to achieve health goals and provide long-term improvement in to the health sectors in the LDCs. Secondly, a broader focus on health concerns is required. HIV/AIDS is an integral component of the health care problem in many LDCs but focusing foreign aid on such policy-specific issues detracts from the improvement of overall health care. Lastly, there is a lack of stability among the allocation of aid to the health sector. Without a focused and coordinated effort to address the pervasive health care concerns, the aid may do more harm than good. Consider the effect of volatility in aid flows on an already unstable economy. If donor commitments are inconsistent and not focused on long-tem goals they are unlikely to create a positive effective on health care goals.

The roles of coordination and information both become a factor when determining why aid has been ineffective. Coordination on the part of the different donors is key to meeting health care goals. Coordination has had an unintended negative effect on health goals up to this point. Based on the global policy method of aid allocation, donors are often influenced by each others choices which can cause shifts in priorities that do not necessarily align with the needs of the recipient countries. For coordination to positively effect aid allocation and outcomes, efforts

between donors must be more connected with the needs of the recipients. This requires increased information between the donors and the recipient countries in terms of what policies would be most effective for the improvement of the long-tem health goals.

This thesis has sought to bring a qualitative analysis of the effects of donor interests and recipient needs to the explanation of ineffective aid. While this thesis has specifically focused on the foreign aid aspect of the health sector, domestic action would also need to take place. A commitment by the LDCs would be necessary in order for the domestic financial resources and political leadership to adequately maintain effective health programs directed to the correct health problems. Additionally, this thesis is also intended to provide a starting point for future research. While academic research is plentiful on the topic of foreign aid, it rarely focuses on specific areas where aid is given, such as the health sector. Much of the literature that exists is produced by the agencies involved in aid giving such as the OECD. Therefore, this thesis can provide a starting point for further research in this area.

While I do feel confident about the findings of this thesis, there are still considerable limitations that must be addressed. Not every possible model of foreign aid allocation could be considered. The models chosen encapsulated a wide range of reasons for providing aid and reasons for ineffectiveness, but other reasons do exist that were not discussed. Also, when considering donor interests and recipient needs, an extensive attempt to outline all the possible interests and needs was not the focus. Entire studies have focused on these two issues and it was beyond the scope of this paper to address the entire range of interests and needs. Also, for future research, a case-by-case analysis of the effectiveness of aid in individual countries classified as “least developed” would produce valuable data concerning this topic. While this would still be considered a small-N study, the data collection and analysis would be considerable. However,

the contribution that it would provide to the area of aid effectiveness, specifically within the health sector, would be invaluable.

In conclusion, coordination of foreign aid between donors and recipients and increased information are the keys for an improvement in the health sector. Coordination must occur both between donors and between donors and recipients and information sharing must increase on every level as well. This research has provided the opportunity to examine the different models of foreign aid and directly apply them to the health care sector. However, the models could be applied to other sectors as well in order to analyze effectiveness in other areas of foreign aid. With a detailed analysis of the models of foreign aid allocation, this thesis has sought to provide a more effective approach for reaching health care goals in the LDCs.

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