

Bilateral versus Multilateral Aid:
Donor assistance to health care in developing countries

David Nabarro

1. Introduction

Most of the papers in this colloquium have examined alternative policies and strategies for improving the health of populations in developing societies. This paper is explicitly concerned with mechanisms through which overseas development aid is provided. How can it be used to assist with the formulation of relevant policies and the successful implementation of sustainable strategies by governments, public and private institutions and other concerned groups within developing countries? The paper examines the advantages and disadvantages of the bilateral aid process. It then considers the potential advantages of multilateral agencies as promoters of development and examines the objectives, workstyle and impact of a number of multilateral aid agencies that utilise donor funds to initiate actions that will affect health. The paper ends with a list of issues that, in the author's view, all bilateral agencies need to keep under continuous review whether they provide finance to developing countries directly or channel their funds through a multilateral agency.

2. The purpose of overseas development assistance: principles and practice

All donor agencies - whether bilateral or multilateral - accept that the underlying purpose of external financial and technical assistance to developing countries is to increase their people's capacity to promote development. External assistance should help them to design and manage effective, equitable and sustainable initiatives. The people of a developing country should be in control of this process, and should determine the priorities for development activities. In many cases, national governments will act on behalf of their people and secure technical and financial assistance for development initiatives from outside. Hence, most donors emphasise the need to work through governments, particularly when they are convinced that they are representing their people's best interests. The situation is a little more complex if a donor agency perceives that a government is concerned with the interests of a small fraction of the

population.

The requests for external assistance generally come from developing country governments to donor agencies - both bilateral and multilateral - through their representative missions in the countries themselves. Donors, of course, have their priorities, too. There is usually considerable dialogue between the government and the donor, and between donors, when such a request is being made.

3. Bilateral donors' priorities

What are the priorities of bilateral donors? Some of these relate to explicit global, regional or local political issues, and the extent of the political influence that the donor wishes to have over the recipient country's government. Such factors have a direct effect on the amount of foreign aid offered to a particular country and to the conditions that may be attached to it. Sometimes there is close co-operation between bilateral donors and aid is channelled through agencies which represent groupings of bilaterals - such as the EEC.

Funds for bilateral aid initiatives have to be provided out of Government resources, obtained through taxation. Government spending is always under scrutiny from parliaments and, increasingly, from pressure groups. Governments of donor countries are therefore unwilling to offer aid if they do not believe that their money will be used to good effect. This consideration applies whether the aid is being channelled through the bilateral process or through a multilateral agency. Hence donors are concerned with the way in which aid funds are being used. When they examine a request for assistance to improve national capacity they will want more detailed information. "Capacity to do what?"; "How will the capacity be improved?"; "How will these improvements be assessed?"; "How will the process of capacity building be initiated, maintained and monitored?" They may be forced to ask "How will the process benefit our domestic interests?" Donors will have views on appropriate mechanisms for improving capacity, and the feasibility and suitability of those proposed by recipient countries. There will be debate and dialogue on these issues within any one donor agency, between donors, and between the donor and the recipient country. Inevitably, therefore, the donor will "interfere" in the process of development if it is providing financial and technical assistance for this process.

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4. The bilateral assistance process in practice.

Requests for financial and technical assistance are usually submitted to donor governments through their diplomatic representatives - ambassadors, high commissioners etc - within developing countries. The decision as to whether the request will be met depends on:

- (a) funds available for the country programme
- (b) the priority given to the sector from which the request has come
- (c) technical appraisal of the request
- (d) the extent to which the request conforms with the donor's policy for the sector

Most donors perceive that assistance for health - particularly for Primary Health Care - is a low priority area. It is usually difficult to show that health aid will have direct benefits for domestic production within a developing country. Usually it provides few commercial opportunities for the donor (unless capital construction - eg hospitals - is involved). At the same time, the donor will probably be short of technical advisers to appraise the request, to examine its feasibility and to assess its potential impact on population health. Most donors recognise that attempts to improve primary level services in any sector - health, agriculture, education, for example - are beset by difficulties and that projects in these areas require considerable investment of management time by well-trained and experienced technical staff. Ideally these will be citizens of the recipient country: in practice, though, there is usually a shortage of personnel with the technical and organisational capacity required by the donor. Often, therefore, external advisers (perhaps employed as consultants) are utilised by the donor to assist with implementation. Personnel who are familiar with the recipient country and its problems are not easily available. As a result, the donor organisation may have limited institutional experience with the management of aid projects in the health sector.

Some donors have explicit policies for their health sector work and try to confine their assistance to meeting requests that fit in with this policy. Requests outside the policy framework may still be considered, but attempts are made, through the process of POLICY DIALOGUE to bring the request within the purview of the donor agency's

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policy. This may cause problems to those who are responsible for receiving requests from the developing country government: a tight donor policy will restrict their capacity to negotiate. As a result, some embassy staff - and their geographical division chiefs - may actively discourage developing countries from submitting requests for health sector assistance. They may be concerned that if the process of policy dialogue does lead to the establishment of a project that fits in to the donor's policy framework, it may prove difficult to implement of the ground because of limited political commitment on the part of the recipient. The result could well be substantial underspending - the cash that is not spent would represent a loss to the recipient country and could, perhaps, have more easily been spent on activities within another sector.

5. Multilateral agencies involved in the health sector: priorities and strategies

Multilateral agencies have usually been established under the aegis of the United Nations for specific purposes. Some have a remit to help governments strengthen their activities in particular sectors (eg health, education, agriculture and food systems, environment, population, industry), others promote the interests of particular population groups (children, labourers). Those most active in the health sector are the World Health Organisation (WHO), the United Nations Children's Fund (UNICEF), the United Nations Fund for Population Activities (UNFPA), and the United Nations Development Programme (UNDP). For the purpose of this paper, it may be useful to consider some WHO special programmes - particularly the Special Programme on AIDS, the EPI programme and the programme for the control of communicable diseases - as though they are separate agencies.

Each multilateral agency expects to receive some core funding from individual UN member countries. Multilaterals have representation in most developing countries: they also keep a small staff which will include a number of technical personnel with experience in health issues and with programming ability. They then co-operate with recipient country governments to propose actions that relate to their agency's interests. Multilaterals differ from many bilaterals in that their policies are quite explicit. Characteristically they initiate detailed reviews of the problems faced by the recipient country's government in the areas which concern them (ie UNICEF reports on the

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status of women and children, UNEPA studies the dynamics of population and acceptance of family planning, WHO studies of the country's health programme). These reviews are then used as the basis for national, regional and even global programming.

Multilateral agencies tend to concentrate on the use of defined strategies for the achievement of their policy goals (eg primary health care, the child survival revolution, contraceptive social marketing). These strategies are often, but by no means always, evolved through operational research; preferred strategies do change from time to time but usually only after new strategies have been endorsed in a major international meeting. The representatives of agencies tend to promote the strategies that they currently favour to recipient country governments - to parliamentarians, opinion leaders and professionals, as well as to civil servants - using sophisticated advocacy techniques. The process of policy dialogue still occurs but in a somewhat one-sided manner. There may be little opportunity for the recipient government to negotiate the financing of a proposal based on strategies other than those advocated by the multilateral. In my experience, representatives of recipient governments involved in such negotiations often consider that they have not had the opportunity to demonstrate that the strategies they propose could achieve the multilateral's goals in a more cost-effective or sustainable manner.

6. Bilateral finance for multilateral agency projects

A multilateral agency's project proposal might cover a small pilot scheme; it is just as likely to be a substantial national, regional or even global programme with a budget of several million dollars. It will usually have precise goals for reducing mortality, fertility or disability; the strategies to be utilised will have been widely described and debated among the donor community and the agency will have worked hard to establish a consensus in support of the strategies that are to be used in the project. The proposal is circulated to bilateral agencies. Donors committed to supporting the policy goals of the agency, and to providing assistance in the country or region covered by the project, will "buy into" it.

This mechanism is to the advantage of bilateral agencies which have limited resources with which to work up health sector projects, and which have committed themselves to a particular rate of

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disbursement of funds for health aid to the support of activities in certain priority countries. At the same time, the bilateral agency's staff will be reassured that the strategies being utilised in a particular noted project are those which have been used elsewhere and have received broad approval from senior health and development professionals. The bilateral agency will not have to expend precious technical manpower to monitor the project - indeed the mechanisms available for individual bilateral agencies to monitor co-financed multi-bi project implementation are not well established. Often a multilateral agency implementing a large national programme is well placed to ensure the co-ordination of other aid activities in the same sector, and donors that have bought into a large country project implemented through a multilateral agency may consider that this action reduces their need to worry about co-ordination problems.

6. The Development Banks

One other group of multilateral agencies operate in a rather different manner. International Development Banks - such as the UN's World Bank, or IBRD, and the Asian, Pan-American and African Development Banks - are important sources of credit for developing country Governments. Because they are mandated to assist countries to undergo social and economic development, much of their lending is directed to the support of specific sectors - and these include population, health and nutrition. Thus a proportion of loans given will be geared to the achievement of the banks' stated policy goals for these sectors. At the same time, the banks have often preceded a dialogue about a loan in any of these sectors with a country sector review, and the loan offer - and the negotiation process - will be conditioned by the findings of such a review. In practice, loans usually go towards the strengthening of the recipient country's human and physical infrastructure so that it is better able to provide health care, population control or nutrition improvement activities in an efficient and equitable fashion.

The maintainance of any government infrastructure carries substantial recurrent cost implications. Banks will therefore be concerned with examining the potential for recipient governments to contain these costs without sacrificing quality or equity. The potential for recipient countries to locate resources to cover the costs of health service delivery - through cost recovery from service

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recipients, redistribution of government resources or resources from non-government resources - will also be examined. Clearly they will want to examine the effect of charging for services on their utilisation by those whose capacity to pay for health care is limited.

7. Future Trends: Hard Questions and Difficult Answers

The potential power of multilateral agencies, and of some of the large bilateral donors, to influence the pattern of health sector activities in developing countries, is becoming increasingly clear. Even the poorest developing countries have to handle conflicts of interest between different pressure groups within their own countries. Each group will attempt to push for an increased share of public resources for the health care activity that it favours. As a result, governments are rarely able to implement strategies that are likely to lead to equitable development without ensuring that there are discernable benefits for those in powerful positions. During the last 15 years, many donors - both through the bilateral process and, particularly, through multilateral channels - have attempted to help developing countries to increase the resources spent on, and services provided for, the most disadvantaged people in their communities. There has been widespread frustration that many countries have not been able to sustain the actions that were initiated with donor support - they have not been able to redistribute resources away from expensive care which reaches a privileged few to appropriate levels of care for the majority. At the same time, the level of resources available to developing country health sectors is not increasing; in many cases the real value has declined substantially in recent years.

There are signs that the donor community has become increasingly concerned about the spiralling costs of curative health care, and the economic burdens faced by developing societies because of the high levels of preventable illness, disability and mortality faced by their peoples. Individuals in developing countries continue to have to make difficult choices about the ways in which they utilise their own resources to maintain or improve their health; their governments, too, are having to decide priorities for public health interventions based on assessments of the severity of the problems their people face and the feasibility of tackling them. A number of donor agencies - particularly multilaterals like UNICEF and the World Bank, often

working in collaboration with bilaterals that have access to groups which undertake operational research in health care - have looked for ways to respond to these problems. They been prompted by the crisis conditions of many developing country health care systems to identify priority problems faced by the populations of developing countries, to assess their economic consequences, to identify cost-effective technologies for tackling them, and to consider alternative strategies for making these technologies available to individuals and communities.

Some donors have started to make explicit their view that national Western-style health care systems cannot possibly be financed from the public purse (the difficulties currently being faced by the British NHS are salutary) and that even if they could be, they are inefficient mechanisms for ensuring the diffusion of health-producing technologies to those who need them. They suggest that complementary pathways - perhaps involving the private sector, supported by well-designed programmes for marketing the technologies and creating demands for them - may be more cost effective mechanisms for helping people to "produce better health".

However, it also seems likely that developing country governments which have struggled hard to try to establish "Western-model" health care systems will face substantial political problems if they attempt to divert their resources towards such new approaches, away from the more conventional pattern. The political problems will be greater still if a government has attempted to meet the total costs of health care through subsidy from the government, and has tried to provide a health care system that is free of charge. The problems will be faced even if the alternative approaches - such as charging the users of curative care at point of service, or using non-health sector channels for dissemination of health producing technologies - can be shown to be more effective in enabling populations to produce better health. The crunch will come as donors attempt to put increasing pressure on developing countries to reallocate resources according to this "logical" rationale: it is likely that the policy dialogue will, in some instances, become a "stand-off". Some bilateral agencies would be extremely concerned if this kind of breakdown in the policy dialogue were to become a reality. There is a real possibility that multilaterals - together with some larger bilaterals - will group together in an attempt to force the recipient government to adopt new

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strategies. There would be a conflict between donors and the recipient about appropriate mechanisms of developing national capacity for health care. There might also be a similar conflict between different bilateral donor agencies, between some bilaterals and the powerful multilaterals, or even between multilaterals.

8. Donor attempts to influence national health policies and strategies: some unavoidable obligations

Both multilateral agencies and some of the larger bilaterals are now explicitly involved in attempts to influence the health sector policies of developing countries through the combination of sophisticated advocacy for particular policies and strategies (eg child survival) and restricting aid to proposals which encompass the favoured strategies. Agencies advocating such selective approaches do have a number of obligations.

- 8.1 They need to be sure that the health problems with which they have a global interest really are the health problems which are of greatest concern to the people of the developing country being offered aid

These problems of greatest concern are not necessarily the same as the problems which cause the greatest mortality or years of productive life lost.

- 8.2 They need to ensure that the health producing techniques that they offer really will
- (a) reduce the magnitude of these health problems, and
 - (b) save the number of lives that they claim to save

A technique that prevents an individual from dying as a result of one disease is not necessarily going to reduce that individual's chance of dying as he/she may still face high risks of death from other conditions and succumb as a result of one of some months or years later. The underlying risk factors will still be present.

- 8.3 They need to check that the mechanism that is proposed for delivering the techniques to the people who need them really

will do this, not just in the immediate short term, but in the longer term too

It is clearly inappropriate for an agency to start to think about sustainability a year or two after a major effort has been put into advocating a specific strategy for delivering health producing technologies: sustainability must be considered from the start

- 8.4 If agencies place their major emphasis on a small number of selected priority problems and particular technologies, to tackle these problems they need to be sure that this will not undermine ongoing activities to improve health in other areas that are, to the people of the recipient country, at least as important as those which have been emphasised by the donor

The opportunity costs of selective public health activities must be considered in the light of restricted planning, managerial and supervisory capacity in all developing countries; claims that selective interventions are the engines on which broader health care interventions can be built need to be subjected to sober economic and political analysis

- 8.5 Agencies should ensure that politicisation of health problems faced by a specific section of the population (children under 3 years, pregnant women etc) through intensive advocacy will not erase other important health issues from public consciousness

In any society there is only a limited number of issues that can be kept in the public eye at any one time: there is always the danger of popular fatigue and disillusion if too many issues are intensively promoted, with excessive claims being made for their potential benefits to the people served.

The dialogue between donors and recipient countries must not be so one sided as to prevent these issues being debated. They need to be debated at many levels. Firstly they should be discussed within the policy dialogue that must take place between aid agencies and

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governments of developing countries. Discussions should also take place within communities in developing countries, inside aid agencies and, particularly, in developing country health and development ministries. Powerful multilateral agencies, involved in high profile international campaigns, may consider that they have too much to lose if they encourage such questioning and debate. Perhaps some of the other donors, who run their shows in a less public way, and do not promise their backers that their efforts will produce dramatic results, have a vital role to play in ensuring that the donor community as a whole meets these obligations. Unless it does, there is a serious chance that in the health sector, at least, the underlying principles of foreign aid will become entrenched rhetoric; that the capacity of developing countries to establish their own priorities for health care will not be strengthened and will, instead, be seriously undermined.

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disbursement of funds for health aid to the support of activities in certain priority countries. At the same time, the bilateral agency's staff will be reassured that the strategies being utilised in a particular noted project are those which have been used elsewhere and have received broad approval from senior health and development professionals. The bilateral agency will not have to expend precious technical manpower to monitor the project - indeed the mechanisms available for individual bilateral agencies to monitor co-financed multi-bi project implementation are not well established. Often a multilateral agency implementing a large national programme is well placed to ensure the co-ordination of other aid activities in the same sector, and donors that have bought into a large country project implemented through a multilateral agency may consider that this action reduces their need to worry about co-ordination problems.

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The potential power of multilateral agencies, and of some of the large bilateral donors, to influence the pattern of health sector activities in developing countries, is becoming increasingly clear. Even the poorest developing countries have to handle conflicts of interest between different pressure groups within their own countries. Each group will attempt to push for an increased share of public resources for the health care activity that it favours. As a result, governments are rarely able to implement strategies that are likely to lead to equitable development without ensuring that there are discernable benefits for those in powerful positions. During the last 15 years, many donors - both through the bilateral process and, particularly, through multilateral channels - have attempted to help developing countries to increase the resources spent on, and services provided for, the most disadvantaged people in their communities. There has been widespread frustration that many countries have not been able to sustain the actions that were initiated with donor support - they have not been able to redistribute resources away from expensive care which reaches a privileged few to appropriate levels of care for the majority. At the same time, the level of resources available to developing country health sectors is not increasing; in many cases the real value has declined substantially in recent years.

There are signs that the donor community has become increasingly concerned about the spiralling costs of curative health care, and the economic burdens faced by developing societies because of the high levels of preventable illness, disability and mortality faced by their peoples. Individuals in developing countries continue to have to make difficult choices about the ways in which they utilise their own resources to maintain or improve their health; their governments, too, are having to decide priorities for public health interventions based on assessments of the severity of the problems their people face and the feasibility of tackling them. A number of donor agencies - particularly multilaterals like UNICEF and the World Bank, often

working in collaboration with bilaterals that have access to groups which undertake operational research in health care have looked for ways to respond to these problems. They been prompted by the crisis conditions of many developing country health care systems to identify priority problems faced by the populations of developing countries, to assess their economic consequences, to identify cost-effective technologies for tackling them, and to consider alternative strategies for making these technologies available to individuals and communities.

Some donors have started to make explicit their view that national Western style health care systems cannot possibly be financed from the public purse (the difficulties currently being faced by the British NHS are salutary) and that even if they could be, they are inefficient mechanisms for ensuring the diffusion of health-producing technologies to those who need them. They suggest that complementary pathways - perhaps involving the private sector, supported by well-designed programmes for marketing the technologies and creating demands for them may be more cost effective mechanisms for helping people to "produce better health".

However, it also seems likely that developing country governments which have struggled hard to try to establish "Western-model" health care systems will face substantial political problems if they attempt to divert their resources towards such new approaches, away from the more conventional pattern. The political problems will be greater still if a government has attempted to meet the total costs of health care through subsidy from the government, and has tried to provide a health care system that is free of charge. The problems will be faced even if the alternative approaches - such as charging the users of curative care at point of service, or using non-health sector channels for dissemination of health producing technologies - can be shown to be more effective in enabling populations to produce better health. The crunch will come as donors attempt to put increasing pressure on developing countries to reallocate resources according to this "logical" rationale: it is likely that the policy dialogue will, in some instances, become a "stand-off". Some bilateral agencies would be extremely concerned if this kind of breakdown in the policy dialogue were to become a reality. There is a real possibility that multilaterals - together with some larger bilaterals - will group together in an attempt to force the recipient government to adopt new

strategies. There would be a conflict between donors and the recipient about appropriate mechanisms of developing national capacity for health care. There might also be a similar conflict between different bilateral donor agencies, between some bilaterals and the powerful multilaterals, or even between multilaterals.

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Both multilateral agencies and some of the larger bilaterals are now explicitly involved in attempts to influence the health sector policies of developing countries through the combination of sophisticated advocacy for particular policies and strategies (eg child survival) and restricting aid to proposals which encompass the favoured strategies. Agencies advocating such selective approaches do have a number of obligations.

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- (a) reduce the magnitude of these health problems, and
- (b) save the number of lives that they claim to save

A technique that prevents an individual from dying as a result of one disease is not necessarily going to reduce that individual's chance of dying as he/she may still face high risks of death from other conditions and succumb as a result of one of some months or years later. The underlying risk factors will still be present.

- 8.3 They need to check that the mechanism that is proposed for delivering the techniques to the people who need them really

will do this, not just in the immediate short term, but in the longer term too

It is clearly inappropriate for an agency to start to think about sustainability a year or two after a major effort has been put into advocating a specific strategy for delivering health producing technologies: sustainability must be considered from the start

- 8.4 If agencies place their major emphasis on a small number of selected priority problems and particular technologies to tackle these problems they need to be sure that this will not undermine ongoing activities to improve health in other areas that are, to the people of the recipient country, at least as important as those which have been emphasised by the donor

The opportunity costs of selective public health activities must be considered in the light of restricted planning, managerial and supervisory capacity in all developing countries; claims that selective interventions are the engines on which broader health-care interventions can be built need to be subjected to sober economic and political analysis

- 8.5 Agencies should ensure that politicisation of health problems faced by a specific section of the population (children under 3 years, pregnant women etc) through intensive advocacy will not erase other important health issues from public consciousness

There is a danger of disillusion if too many issues are intensively promoted, with excessive claims being made for their potential benefits to the people served.

The dialogue between donors and recipient countries must not be so one sided as to prevent these issues being debated. They need to be debated at many levels. Firstly they should be discussed within the policy dialogue that must take place between aid agencies and

governments of developing countries. Discussions should also take place within communities in developing countries, inside aid agencies and, particularly, in developing country health and development ministries. Powerful multilateral agencies, involved in high profile international campaigns, may consider that they have too much to lose if they encourage such questioning and debate. Perhaps some of the other donors, who run their shows in a less public way, and do not promise their backers that their efforts will produce dramatic results, have a vital role to play in ensuring that the donor community as a whole meets these obligations. Unless it does, there is a serious chance that in the health sector, at least, the underlying principles of foreign aid will become entrenched rhetoric; that the capacity of developing countries to establish their own priorities for health care will not be strengthened and will, instead, be seriously undermined.

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