

Viewpoint

Trading ideology for dialogue: an opportunity to fix international aid for health?

Ines Périn, Amir Attaran

"We don't know if it works but we know what's good for you"

B Chitah, Central Board of Health, Zambia, 2001.

In 1910, the Nobel laureate, Ronald Ross, propounded in his famous sanitary axioms "Widespread diseases . . . cause much pain, poverty, sorrow, expense and loss of prosperity. . . and the rule is to grudge spending a hundred pounds for disease which costs thousands".¹ Although the amount of development aid spent on health has increased since that time, the logic behind aid administration remains controversial. Both the professional and lay press report that, despite some successes, development aid for health has not realised its goals, often because of inadequate or harmful policies.²

In this article, we track the evolution of the policies of the major bilateral and multilateral aid donors since the 1960s. We argue that those policies, instead of reflecting needs of the recipient countries, have evolved in response to donors' ideologies. Aid policies emerge from a monologue of donors, rather than a dialogue including recipients, despite window-dressing to mask this reality. This lack of dialogue underscores most of the failures of international health and suggests the urgent need for a restructured aid process, in which policies and projects are not merely guided, but actually designed, by recipients.

Major trends in policy

Why do donors have such a heavy influence on health policies in developing countries? Donors' contributions account for perhaps 3% of total health expenditure in developing countries, but influence policy and steer the spending of the remaining 97%.³ Clearly, other aspects of politics and international relations are used to wield influence over health policy, not just this small financial contribution. The table summarises the major health policy movements of multilateral donors in the past four decades.^{4,5}

In the 1960s, macroeconomic growth was seen as the ultimate remedy for underdevelopment. Growth strategies emphasised state-led capital investment in large infrastructure projects. This emphasis affected donors' health projects, which often centred on large, high-investment projects such as water and sewerage systems and hospitals. At the same time, WHO policy favoured vertical

programmes of disease control, such as the malaria and smallpox eradication campaigns that had been launched a decade earlier.⁶

In the 1970s, these approaches were attacked for benefiting urban but not rural areas. The appalling conditions of poor, rural people were being discovered in places such as Somalia and Biafra, thanks largely to non-governmental organisations advocating for crisis relief.⁷ Emerging public scepticism of transnational commerce led the World Bank, in 1975, to concur "the private market cannot be expected to allocate to health either the amount or the composition of resources that is best from a social perspective".⁸ These influences redirected development toward human, rather than economic, objectives, best expressed in WHO's *Health For All* strategy that emerged from the 1978 Alma-Ata summit. Thus, primary health-care and services at the village level supplanted the former emphasis on grandiose infrastructure investments and centrally planned, vertical health programmes.

Alma-Ata might have propelled primary health-care into the 1980s, if it were not for the international financial events of that decade. With the 1982 Mexico debt crisis, development became dominated by an obsession with macroeconomic fundamentals (tellingly, since the same donor countries were also the creditors whose unpaid loans were at risk), thus ending the short reign of human development. The World Bank became the leading purveyor of structural adjustment and shock therapy—macroeconomic panaceas based on the Washington Consensus that economic stability and development were best achieved through disciplined privatisation, deregulation, and trade liberalisation, often at the expense of social spending. Although the World Bank increased health lending by about six-fold in the 1980s, loans were usually conditional on following the Bank's broader economic policies.⁹ The primacy of economic over health considerations became so accepted that non-financial institutions such as WHO and UNICEF spearheaded policies such as the 1987 *Bamako Initiative*, which introduced the astonishing principle that the world's poorest countries (in Africa) should implement user fees and cost recovery for public health services.

By the 1990s, the human cost of this economic singlemindedness was acute and embarrassing.¹⁰ International agencies responded with self-critical reports such as *Adjustment with a Human Face* (UNICEF, 1987) and the *World Development Report: Poverty* (World Bank, 1990), which reported that a decade's obsession with structural adjustment had crippled health programmes, often doing the most harm to the poorest people. Yet little changed, and the World Bank's report *Investing in Health* (1993) retained the familiar, economic prescriptions: support only the most cost-effective health interventions, impose user fees for health services, privatise health systems, and create public-private partnerships. New concepts for managing health aid emerged, such as the sector-wide

Lancet 2003; **361**: 1216–19

AXIOS International, Paris 75001, France (I Périn MD); and Carr Center for Human Rights Policy and Kennedy School of Government, Harvard University, Cambridge, MA, USA (A Attaran DPHI)

Correspondence to: Dr Amir Attaran, Carr Centre for Human Rights Policy, 79 JFK Street, Harvard University, Cambridge, MA 02138, USA (e-mail: amir_attaran@harvard.edu)

	World Bank	UN	European Commission
Year			
1960	Economic growth against poverty Infrastructures (water, sanitation, etc)	Vertical disease control Diarrhoea, malaria, tuberculosis, etc	Economic integration Rome Treaty, 1957
1970 1975–78	Poverty alleviation Health policy paper	Vertical disease control Alma-Ata Summit health policy (<i>Health For All</i>)	Poverty alleviation Lome Convention, 1977* Infrastructures (eg, hospitals)
1980 1981	Structural adjustment WDR adjustment and growth health policy paper Health loans	Primary health care and essential drugs Adoption of global strategy of <i>Health For All</i>	Rural development Rural development programmes
1987	WDR barriers to adjustment	Policy for polio eradication. <i>Bamako Initiative</i> (WHO, UNICEF). 1st AIDS control programme	Structural adjustment in Latin America
1989	Financing in health and cost recovery WDR financial systems	<i>Adjustment with a human face</i> , UNICEF	NA
1990 1990	Agenda for reform WDR poverty	Health systems development Children vaccine initiative	Integrated development 1st health programmes
1993	WDR <i>Investing in Health</i>	SWAP papers	Asia, Latin America
1996	NA	Review of <i>Health For All</i> strategy	NA
1997	WDR role of state. HNP strategy	Bridging the gaps for <i>Health For All</i>	Programme aid
1999	Good governance	NA	SWAPs
2000	Poverty Poverty reduction sector programme	Disease control Malaria, AIDS, tuberculosis	Poverty and disease control Cotonou Convention*

NA=not applicable. WDR=world development report. HNP=health, nutrition, and population. SWAP=sector-wide approach programme. *Lome and Cotonou Conventions are agreements between 77 African Caribbean and Pacific countries and the European Commission containing the objectives and rules of European Commission aid.

Major health policy trends

approach to plan budgets and programmes. In short, aid donors spent the 1990s absorbed in how to run gutted health systems with the greatest managerial efficiency, while doing much less to restore the lost health services that could have saved lives.

At the start of a new century, policy change is again underway. Despite a stated emphasis on health systems, several new programmes focus on a single disease or single intervention as the old vertical programmes did. The lost emphasis on health for all and equity appears to be returning, with WHO declaring in 2001: "Poverty and inequity [are] the proper focus of the new century", and the WHO Commission on Macroeconomics and Health endorsing village based, close-to-client health services.^{11,12} Looking ahead, several of the UN's millennium development goals (MDGs) set ambitious targets for AIDS, malaria, poverty reduction and the like that must be met by 2015.¹³ Health policy therefore remains in flux.

Where is the logic in aid policy?

Quite clearly, health policy has shifted emphasis many times over the years, which is remarkable for two reasons both of which indict the legitimacy of the past and current aid system. The first difficulty is one of causality. While donors' health policies and strategies have evolved over time, there is no corresponding evidence that health needs in developing countries were changing in ways that justified these policy shifts. In fact, the health problems facing the poorest people have remained remarkably constant.

The second difficulty is one of misplaced ideology. If donors' shifting policies and strategies were not related to recipients' health needs, they were instead made to fit the contemporary political, economic, or managerial ideology of the donors. Health policies therefore operate from the top down, with donors shaping the organisation, management, priorities, and rules of access to aid, and very seldom from the bottom up, with the recipients making these choices.

Policy and needs

There is a widespread belief that an epidemiological transition has shifted the heaviest disease burden from communicable to non-communicable causes. However, although this shift has occurred in high-income and

middle-income countries, for the world's poorest people, concentrated in low-income countries, infectious diseases still account for 60% of mortality, including acute respiratory and gastrointestinal infections, tuberculosis, and malaria.^{14,15} In sub-Saharan Africa, infectious causes of death show little decrease—from 48.2% in 1970 to 47.2% in 1985 and 41.8% in 2000—and even this will probably be reversed by HIV/AIDS in coming years.¹⁶

Given this dismal record, 40 years of aid giving has not been highly successful in improving the health of the world's poorest people. Their health needs have been constant, but the policies of aid donors have repeatedly changed. In fact, policy has largely returned, unconsciously and almost cyclically, to objectives that were in vogue in the 1960s and 1970s: today's focus on poverty alleviation, close-to-client health care, and equity hardly differs from the *Health For All* policy of three decades ago.

Implementation has also followed an unconscious and cyclical course. For example, vertical programmes aimed at a single disease (eg, malaria) or using a single intervention (eg, smallpox vaccine) died out when policy favoured primary health care. But vertical programmes are back: the Global Alliance for Vaccines and Immunization, the Global Fund for AIDS, Tuberculosis and Malaria, and the International Trachoma Initiative all fund single diseases or propound single interventions—though vertical remains a taboo word. Similarly, donors have changed policy several times with respect to who should operate health programmes: from the public sector in 1960s and 1970s to the private sector with privatisation in the 1980s and 1990s. Now donors enthuse about public-private partnerships and the need to involve civil society.

Absolutely none of these policy shifts can be attributed to a change in the health needs of poor countries. Instead, they are an embarrassing testament to donors' unreasonable caprice, where trends often seem to matter more than teleology in setting public health policy.

Fashions and aid proselytism

So, what causes aid policies to shift radically or even travel full circle? We think that donors' political and economic ideology, far more than the biomedical imperatives of disease, drives health policy. A clear example is the

Bamako Initiative, which WHO and UNICEF imposed in 1987, reversing the equity approach of *Health For All*. This policy change came about when it was fashionable to view development predominantly in economic terms and during the fiscal stringency of structural adjustment, when it was popular to shift the costs of services to users. Although this policy was attractive financially, as a health policy it proved foolish. User fees dissuade the poorest people from accessing health services, while collecting very little revenue.¹⁷ Rarely do such fees raise more than 5% of recurrent health costs—one flagship *Bamako Initiative* project raised a few cents—probably about the cost of collecting the fee.^{18,19}

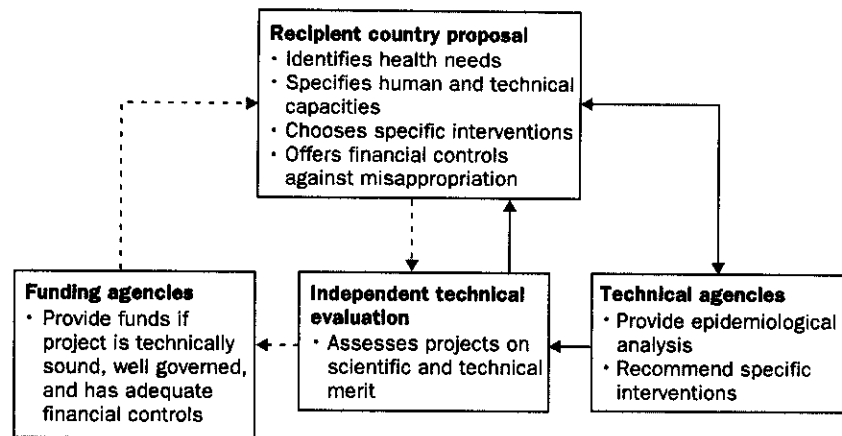
Donors credit the *Bamako Initiative* for boosting vaccination coverage (to 73% for diphtheria, pertussis, tetanus, and polio in Guinea in 1995), but ignore poor results in later years (48% in 1996 and 57% in 1999).²⁰ UNICEF's executive director even touted the *Bamako Initiative* for "improved and sustained immunization coverage", although WHO vaccination statistics showed the opposite to be true.^{19,21,22} Only now, more than a decade into the *Bamako Initiative*, are WHO and UNICEF admitting their errors and concealment, declaring that "user fees discourage [poor] people from seeking vaccination."²³

What explains such an obvious mistake as the user fees fiasco? Donors back health policies that mirror their own domestic political or economic ideologies, thus turning aid into proselytisation. This attitude is clearest when donors refuse to fund programmes because of domestic political beliefs (eg, the USA's refusal to fund population control programmes involving abortion), but subtler proselytisation disguised as guidance also exists. Consider a recent World Bank book about health finance: after surveying the experiences with user fees of Japan, Germany, and the USA, the Bank declared these as "Lessons for developing countries", with little weighing of the adverse evidence for user fees in poorer economies.²⁴ Donors can even be so wedded to their ideology and policies that they suppress evidence of failure, as UNICEF did. The triumph of ideology over evidence in aid policy is devastating, because it serves donors' priorities above the forgotten actual health needs of recipients.^{25,26}

The solution

What will it take to break the march of ephemeral aid trends? Probably not a new set of donor-dictated priorities such as the MDGs. However laudable the goals are—and it is impossible to argue with health, poverty reduction, etc—making them centrepieces for development, as the UN is increasingly doing, is unwise. All previous trends, later abandoned, were once celebrated in this way.

Our point is that when donors become suddenly enthusiastic about a new health policy, they zealously proselytise it to poor countries, and history teaches how useless this approach has been. If donors start to pressurise poor countries to take steps to advance the MDGs, because that is the orthodoxy and there are goals to be met in 2015, and do not listen to developing countries and give them the aid they want, then the MDGs will be another trend indulged for the sake of donors rather than recipients.



Technical and financial flow of an Ideal aid scheme
Solid lines=technical flow, broken lines=financial flow.

We think the correct approach lies in dialogue: donors must invite recipients to propose and design their own health projects, using the interventions that the recipients want; and donors must agree to fund these proposals, on the basis of (1) whether the proposals are technically sound and (2) whether the recipient needs external funds and (3) is fiscally accountable. All three considerations address whether the donor's money will be well spent, but none steers the developing country into ideological conformity with the donor.

The figure shows the ideal aid scheme—one in which the needs of recipient countries are paramount. The identification of need starts with the aid recipient, who seeks the cooperation of technical agencies (eg, WHO) to develop an aid proposal, which is then promoted widely for funding. The proposal is assessed to ensure it uses technically and medically sound interventions (ie, not quackery), and similarly, the government's performance is assessed by past performance for fiscal probity and security from corruption. Countries that score well on these criteria should receive financial aid, at much higher levels than they do now—even if this means withdrawing all aid from countries that have irrational medical policies (eg, South Africa's African National Congress government and its stance on HIV/AIDS) or are undoubtedly corrupt (eg, Zimbabwe). The aim is to give proactive, well run countries exactly the aid that they ask for, and can technically and medically justify, in generous amounts, appropriate to need, and yielding maximum return on investment in aid spending.

Encouragingly, this model is being tested in the new Global Fund for AIDS, Tuberculosis and Malaria.^{27,28} Whether the fund works as intended remains to be seen. Worryingly, some foolish mistakes were made in the first round of grants: after the fund espoused support for the poorest countries, large sums of money were awarded to Chile and Argentina, but Malawi was turned down; and after insisting that recipients show exemplary governance and financial accountability, grants were approved for North Korea and Zimbabwe. We hope that these are teething pains that will pass, because the fund's core principles are sound: donors advocate why to intervene, and deliver the financial backing of their governments; technical agencies (such as WHO) research and perfect how to intervene, and deliver that expertise; and recipients are left to choose which health problems and projects require intervention, consistent with their own priorities.

If this division of responsibilities is respected, some of the most embarrassing—and persistent—mistakes of

international aid can be avoided. The fund can help connect the three players and encourage regular dialogue, while hopefully enlarging the intersection at which agreement and successful aid projects meet. Done this way, aid for the health sector has a bright future. Done otherwise, we expect only the rhetoric to change.

Contributors

Both authors contributed equally to the research and writing of this manuscript.

Conflict of interest statement

I Périn has worked as an employee of DG-Development of the European Commission. A Attaran has worked as a paid consultant for the UN Development Programme.

Acknowledgments

We thank Prof Michael Reich for his comments on the manuscript. During the preparation of the manuscript, I Périn was a Takemi Fellow at the Harvard School of Public Health, and A Attaran was funded by core funds of Harvard University and an unrestricted grant from the Africa Fighting Malaria Foundation. The sponsors of the study had no role in writing this article.

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