

## ARGUMENT

# The Case for Aid

It's become fashionable to argue that foreign aid doesn't make a difference. Here's why the critics couldn't be more wrong.

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I have long believed in foreign aid as one tool of economic development. This is not an easy position to maintain, especially in the United States, where public misunderstanding, politics, and ideology all tend to keep aid an object of contempt for many people. Yet the recent evidence shows that development aid, when properly designed and delivered, works, saving the lives of the poor and helping to promote economic growth. Indeed, based on this evidence, Bill and Melinda Gates released a [powerful letter](#) to the public today also underscoring the importance and efficacy of foreign aid.

As experience demonstrates, it is possible to use our reason, management know-how, technology, and learning by doing to design highly effective aid programs that save lives and promote development. This should be done in global collaboration with national and local communities, taking local circumstances into account. The evidence bears out this approach.

Of course, I do not believe that aid is the sole or main driver of economic development. I do not believe that aid is automatically effective. Nor should we condone bad governance in Africa — or in Washington, for that matter. Aid is one development tool among several; it works best in conjunction with sound economic policies, transparency, good governance, and the effective deployment of new technologies.

Professor William Easterly of New York University has long been a vocal opponent of aid, and recently declared that the aid debate was "[over](#)," claiming victory for his theory that large-scale aid projects are doomed to fail. This blanket claim flies in the face of recent experience. Prof. Easterly has been proven wrong in both diagnosis and prescription.

During the past 13 years, the greatest breakthroughs in aid quantity and quality came from the field of public health (unlike other social sectors, such as education and sanitation, where aid increases were far less notable). As a result, the outcomes in

public health in poor countries have also advanced markedly. Not only did aid quantities for public health improve; new public health institutions, such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria and the Global Alliance for Vaccines and Immunization, were created to promote the effective delivery of the increased aid.

The approach of increased aid that is well targeted through innovative institutions has been enormously successful in improving public health in low-income countries. One could cite many examples ranging from the scale-up of vaccine coverage (largely through GAVI and UNICEF) to increased treatment coverage for HIV/AIDS and expanded tuberculosis control (through the Global Fund and the U.S. PEPFAR program), but I will focus specifically on malaria control, since Prof. Easterly was particularly pointed in his opposition to the mass scale-up of malaria control that has proved to be so successful. Fortunately, the global community did not heed Easterly's erroneous advice, and followed a path that the public health community strongly advocated.

At the turn of the new century, malaria was front and center of the global aid debate. Research by myself and others, and evidence garnered in the report of the World Health Organization (WHO) [Commission on Macroeconomics and Health](#) that I had the honor to chair, showed that in addition to being a health catastrophe, malaria imposes a significant economic burden, particularly in sub-Saharan Africa. Luckily, though, the world was starting to take notice. In 2000, the U.N. Millennium Declaration, The African Summit on Malaria, and the G8 Declaration all addressed the burden of malaria and committed the world to action. The debate soon turned to the issue of policy: how could the malaria burden be reduced?

Here we must look at some key details in order to keep aid in careful perspective. Starting in the late 1990s, malariologists at WHO, in academia, and in various government agencies around the world, described how malaria control could be made highly effective. The malariologists emphasized the ability of insecticide-treated bed nets to reduce the transmission of the disease. They also emphasized the urgency of shifting to a new generation of first-line medicines, notably those using artemisinin (a powerful anti-malaria drug developed by Chinese scientists) in combination with other medicines, because the old-line medicines (mainly chloroquine) were losing efficacy to growing drug resistance. The combination of bed nets and effective medicines (known in the jargon as "vector control" and "case management" respectively), supported by rapid diagnosis of infections, makes for a powerful one-two punch in saving lives and reducing malaria transmission.

Indeed, epidemiological theory and practical experience strongly suggested that if bed net coverage could be raised to a sufficiently high rate (typically around three-quarters, depending on local conditions), the transmission of malaria would be sharply reduced even for those not directly protected by their own bed nets. The "spillover" of protection to the non-users is called a mass-action effect, similar to the way that high vaccine coverage protects even unvaccinated people because the disease stops spreading when fewer people are susceptible to infection. This mass-action phenomenon of course strongly argued for a malaria control strategy that would lead to a high level of bed net coverage.

There was one more detail of great policy significance: Not all bed nets are equal. The high-quality bed nets work not only mechanically (by covering the body) but also chemically, by a treatment with insecticide that repels or kills mosquitoes that land on the bed net. A bed net without insecticide treatment is far less effective than a treated net. Until the early 2000s, bed nets required frequent retreatment with insecticide (e.g. by bathing the nets in tubs filled with insecticide) in order to remain effective. Then, Sumitomo Chemical developed long-lasting insecticide-treated nets (LLINs) that were specially engineered to keep the insecticide intact even when the nets were repeatedly washed. The new nets could therefore remain effective for around five years or even more. Other companies, such as Vestergaard and BASF, also developed their own varieties of LLINs. This was a great breakthrough, but the new nets were more expensive to manufacture than the preceding generation of simpler nets. (In the photo above, South Sudanese children are taught how to use LLINs.)

All of these developments — new nets, new medicines, improved diagnostics, and a surging epidemic — were crucial to developing a successful malaria control policy after the year 2000. Taken together, they motivated the case for increased donor aid to support the mass free-distribution of LLINs and free access to the new generation of artemisinin-based medicines and rapid diagnostic tools. Without financial support, poor people could not afford either the LLINs or the new medicines. Attempts to sell the nets at a discount, known as social marketing, had very little take up, since many poor families simply lacked any cash income at all. The prospect of achieving "mass action" protection through social marketing was very small. Moreover, impoverished households would often scrape together the needed money only to buy the cheaper but ineffective nets, rather than the more expensive but more effective LLINs.

Governments of low-income African countries needed donor support for the scale-up effort since their own domestic tax revenues, even when amply allocated to public health, could not cover the costs of a basic primary health system including scaled-up

malaria control. The financial calculations, laid out by the Commission on Macroeconomics and Health, showed that an impoverished country with a GDP of around \$500 per capita, typical for a poor country in Africa, may be able to muster around \$15 per person per year out of domestic revenues for primary health (directing 15 percent of domestic revenues to health, as the Abuja target for health spending recommends), while the costs of a basic public health system (measured in 2014 dollars) would be around \$50-\$60 per person per year.

Prof. Easterly would have none of it. He took special and early aim at these recommendations in his 2006 book *The White Man's Burden*, claiming that free nets "are often diverted to the black market, become out of stock in health clinics, or wind up being used as fishing nets or wedding veils." After this specious claim, he then went on to write that "a study of a program to hand out free [malaria bed] nets in Zambia to people ... found that 70 percent of the recipients didn't use the nets." Yet this particular study, which was conducted by the American Red Cross and CORE, actually showed the program was a success, with high rates of net adoption. Prof. Easterly's claim misconstrued this and other evidence being developed by the ARC and others about the mass distribution of nets, which had found that the free distribution of malaria bed nets was achieving high coverage and adoption rates.

Prof. Easterly's arguments added to a highly visible narrative against the needed global action on malaria control. Yet despite this anti-aid narrative, a global turning point finally came in 2007-08. This turning point was helped by the early success of Kenya. Kenya's Minister of Health at the time, Charity Ngilu, led a government effort during 2006-7 to scale up mass bed net distribution based, in part, on the example of free LLIN distribution in the Sauri Millennium Village. Kenya's policies led to a sharp drop of malaria nationwide.

Next, WHO swung its powerful weight behind the mass free distributions of bed nets throughout sub-Saharan Africa. Soon after, U.N. Secretary-General Ban Ki-moon established the mass free distribution of bed nets as policy for all U.N. agencies, and called on the world's governments and NGOs to support the scale-up effort. Ban's leadership tipped the global scales decisively. Close to 300 million bed nets were freely distributed from 2008-2010, with the Global Fund to Fight AIDS, Tuberculosis and Malaria and the U.S. President's Malaria Initiative program paying for a substantial share of the scale-up.

The evidence is overwhelming that malaria declined precipitously as a result of these bold measures. WHO's latest report finds a stunning 51 percent drop in malaria deaths

of African children under the age of five between the years 2000 and 2012. These results are historic. Roughly a half-million children, if not more, are being saved each year that otherwise would have succumbed to malaria. Even more success is possible, but only if development aid continues to back the effective control of malaria. The Global Fund is struggling to fill its request for \$5 billion per year of funding, essential to supplement the health budgets of poor countries. Prof. Easterly's continued denunciations of aid, and his declarations that large-scale aid has failed, are injurious to the public support needed for the replenishment.

Across the board, the post-2000 improvements in public health in sub-Saharan Africa have been dramatic, strongly supported by scaled-up aid. Up to 10 million HIV-infected individuals are now **receiving** life-saving, anti-retroviral medicines thanks at least in part to aid programs. Tuberculosis (TB) patients are being treated and cured, with a global TB mortality rate drop of 45 percent since 1990, and an estimated **22 million** people alive due to TB care and control from 1995-2012, thanks to Global Fund support, which provides the **lion's share** of donor financing to fight TB. With increased donor support, antenatal health visits, institutional deliveries, and access to emergency obstetrical care are all on the increase, contributing to a **decline** in sub-Saharan Africa's maternal mortality rate (the annual number of female deaths per 100,000 live births) from 850 in 1990 to 740 in 2000 to 500 in 2010. Deaths of children under five worldwide have **declined** from 12.6 million a year in 1990 and 10.8 million in 2000 to 6.5 million in 2012.

These successes demonstrate a key lesson: that well-designed aid programs with sound operating principles, including clear goals, metrics, milestones, deliverables, and financing streams, can make an enormous difference, and that such programs should be devised and applied on a large scale in order to benefit as many people as possible. Such quality design needs to be based on the details of best practices, such as the combination of medicines, bed nets, and diagnostics used in cutting-edge, community-based malaria control. The economics profession needs to do a much better job working with experts in other fields, such as public health, in order to design effective aid interventions that reflect the nitty-gritty of high-quality systems delivery. While Prof. Easterly begrudgingly admits that some health aid programs have worked, for him this contradiction seems to make no difference to his overarching claim that aid is doomed to fail, for reasons that are hard to explain. All the evidence and all the exceptions have not mattered to his rhetoric, or for that matter, to his harsh attacks on me personally.

The aid successes of the past decade have saved millions of lives, a worthy use of money (which has totaled just a tiny fraction of rich world income) on its own. Yet aid has

delivered more than lives saved and improved. Various kinds of aid, including public health outlays, debt cancellation under the IMF and World Bank's Heavily Indebted Poor Countries initiative (providing debt relief and cancellation for the poorest countries), and other programmatic and budget support, have helped to put sub-Saharan Africa on a path of much higher economic growth and development. For the first time in decades, Africa's poverty rate has **come down notably** (from 58 percent in 1999 to 48.4 percent in 2010) and the region's economic growth is now around 5 percent per year, making it the region with the second fastest growth (following Asia).

Of course, aid didn't cause this success by itself, as there are many factors in play. But aid has helped. Research distinguishing the types and timing of aid has shown that **development aid raises economic growth**, though the effects will differ across countries and depend on the quality of aid. The malaria example is one of the clearest and most dramatic examples, but across the continent, aid has helped with improvements in education, agriculture, sanitation, infrastructure, and more.

In *The White Man's Burden*, Prof. Easterly declared, "You just have to do whatever you discover works with your modest resources to make a difference in the lives of poor people." Prof. Easterly's emphasis on "modest resources" mischaracterizes our real global situation. We are living in a world of great wealth. We need not accept the fallacy perpetuated by the rich that global resources available are quite so "modest," when total aid to sub-Saharan Africa in 2012 amounted to **roughly 0.1 percent** of the GDP of the donor countries (around \$45 billion per year). We can and should mobilize more support. Just fractions of 1 percent of GDP of the rich countries can make a profound difference to ending extreme poverty throughout the world. Of course, we should also certainly agree to focus on what works, and take effective programs to large scale. The positive evidence since 2000 shows that well-designed aid has made a tremendous impact.

The issue is not "yes" or "no" to aid. Aid is needed, and can be highly successful. The issue is how to deliver high-quality aid to the world's poorest and most vulnerable people.

