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Shifting official development assistance during COVID-19: earmarking, donor concentration and loans

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ABSTRACT

Context In contrast to bilateral aid, aid disbursed from multilateral institutions increased significantly at the onset of the COVID-19 pandemic. Yet, at a time when a coherent and effective multilateral response is needed most, the COVID-19 pandemic revealed a shifting landscape of donor agencies that struggle with basic functions, such as cross-national coordination. While multilaterals are uniquely positioned to transcend national priorities and respond to pandemics, functionally we find official development assistance (ODA) from these entities may increasingly mimic the attributes of bilateral aid. We explore three important, but not comprehensive, attributes of aid leading up to and during the COVID-19 pandemic: (1) earmarking, (2) donor concentration and (3) aid modality.

Methods We examine ODA disbursements over time in 2020 constant prices from 2010 to 2021 and plot share of inflow that is earmarked against each United Nations multilateral against their average annual financing volume. We then assess market diversity with two measures: the Shannon-Weiner Function and Gini-Simpson Index. Finally, we examine financing vehicles used to disburse and look at 'grant share' of total ODA from all formal donors over time.

Findings We find that while the absolute number of formal multilateral actors and market diversity have been increasing since 2011, there has been a concurrent market consolidation led by the World Bank Group at 37% of market share in 2021. This coincides with an increasing prevalence of earmarking of aid inflows to the multilateral system and, unique to multilaterals but concerning given increasing debt risk, a rise in loan-based ODA disbursements.

Conclusions In theory, this consolidation may streamline revenue pooling and allow for a more collective approach to mitigating pandemic risk but, paired with increased earmarking, has the potential to sideline both collective goals (eg, the Sustainable Development Goals) and counties' core mandates (such as the pursuit of universal health coverage).

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Official development assistance (ODA) channelled through multilaterals increased during COVID-19 compared with direct bilateral assistance.
⇒ For many, multilateral institutions offered much needed support to mitigate global crisis, being uniquely positioned to take a global approach to financing and needs.

WHAT THIS STUDY ADDS

⇒ We find development assistance distributed through multilaterals may increasingly mimic attributes of bilateral aid (ie, earmarking of funds).
⇒ Moreover, an increase in the absolute number of multilateral entities stands in contrast to the market becoming more concentrated, with a small number of players (eg, the World Bank Group) controlling the majority of aid.
⇒ These trends correspond with an increase in loan-based disbursements; further indebting poor countries.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Taken together, the data presented in this study raise concern regarding increasing avenues through which a small number of donors exert control over the ODA landscape.

INTRODUCTION

COVID-19 has had a profound impact on the need for official development assistance (ODA), including humanitarian aid. On the demand side, recipient health systems faced an increased burden globally, as they fought the pandemic and worked to maintain routine health services; requiring significant domestic and alternative funding streams. A consequence has been reversed progress on the number of countries graduating from low- to middle-income status. On the supply side, donors also managed the pandemic 'at home', stretching wealthier countries' disbursement portfolios. Taken together, there is significant potential for ODA changes to disrupt the achievement of national and global universal health coverage (UHC) agendas by 2030, the Sustainable Development Goals (SDGs) and broader health system strengthening efforts. In line with this concern, data compiled by the International Aid Transparency Initiative

suggest overall bilateral donor disbursements (those provided directly from donor countries to recipients) remained relatively constant or fell during the pandemic. However, in contrast, multilateral aid (ODA pooled and distributed by entities like the World Bank and United Nations (UN) agencies) increased in both relative and absolute terms.[1] This may represent a positive shift: multilateral agencies offer a unique vantage for coordination and prioritisation of aid that transcends national priorities.

In 2016, the Overseas Development Institute characterised bilateral channels as highly politicised compared with multilateral; leading recipients to prefer multilateral aid.[2] Multilaterals can, in theory, focus on cross-national development outcomes, while bilateral aid is often seen as a mechanism to achieve donors' strategic interests.[3 4] Moreover, due to pooling functions of multilaterals, ODA dispersed through these entities may be less fragmented and better structured to achieve common global causes or support international governing frameworks, such as the implementation of International Health Regulations.[5 6] Evidence suggests multilateral aid is more efficient in reaching stated objectives[7] and following Organisation for Economic Co-operation and Development (OECD) 'best practice' guidelines; including serving recipient needs as opposed to donor priorities.[8] Consequently, the data on a shifting ODA landscape during COVID-19 were promising: a higher share of ODA disbursements flowing through multilaterals may be uniquely relevant in addressing global threats and achieving cross-national global agendas. Yet, the pandemic revealed an aid landscape of donor agencies that struggle with coordination in fundamental ways: conflicting prioritisation, delays in disbursement and a failure of multilateralism with regard to global public goods and vaccines.[9 10] An increase in multilateral expenditure, through actors whose disbursement practices are not subject to more democratic processes, therefore raises questions regarding global health governance, multilateral power and influence in the wake of the pandemic. For example, voting at the World Bank Group (WBG) is often characterised as 'one dollar, one vote', with influence concentrated among countries most able to pay.

The increase in multilateral ODA also coincides with an unprecedented surge in public debt.[11] To expand health provision during the pandemic while mitigating long-term damage to the economy and facilitating recovery, governments pursued 'expansionist' fiscal policies, leading to budget deficits and compounding debt stress.[12] In addition, the debt-to-gross domestic product ratio in developing countries is expected to rise, threatening the well-being of individuals. In light of this, the Government of Barbados has called for liquidity to stop the debt crisis, asking the G20 to agree to an ambitious Debt Service Suspension Initiative that includes all multilateral development bank (MDB) loans.[13] Debt-related strains may compound broader social fractures surrounding the unequal burden associated with post-COVID recovery.[12] Thus, the potential of multilateral entities as a neutral third party through which ODA can be distributed is increasingly relevant as countries strive to achieve non-pandemic-related health goals.[14] Despite these concerns, we lack a critical examination of ODA from multilaterals and how this type of aid has shifted in light of COVID-19. We hypothesise that while there has been a shift towards multilateral financing, functionally this transition may mimic issues of a bilateral-dominated market: reaffirming, rather than addressing, issues of donor influence.

We address three primary research questions motivated by recent increases in multilateral ODA: (1) How is earmarking borne out through different multilateral agencies and for different types of aid? (2) We then examine market concentration—how diverse is the ODA landscape, to what extent is the multilateral system concentrated and has this changed over time? (3) Finally, implications for financing allocation vehicles—what does an increase in multilateral ODA mean for financing modalities used, and the potential for low- and middle-income country debt sustainability? Specifically, we look at ODA repayment expectations and distribution of ODA outflows in the form of grants versus loans. Accordingly, we consider what these might mean for donor influence across the global health landscape.

BACKGROUND

This section outlines a contextual framework for examining aid contingencies, concentration and allocation. The framework extends beyond a binary distinction of 'bilateral' versus 'multilateral' by focusing on the aid market and practical attributes of aid itself. This diverges from prior examinations that centre donor motivation (eg, ideational, political, commercial, security related or cultural) or recipient capacity.[15]

Earmarking

One method of exercising donor prioritisation is through earmarked contingencies. In a 2017 examination of the experiences of domestic policymakers in Cambodia and Pakistan, Khan *et al* identified control of financial resources as the most common route by which donors influenced priority setting.[16] While multilateral aid is initially provided by many of the same actors as bilateral aid (eg, wealthy nations), it is then pooled by multilateral organisations, after which it is disbursed. The role of 'multi-bilateral' aid—commitments voluntarily provided to multilateral organisations (from both countries and private entities) but earmarked for specific purposes—has the potential to shift this dynamic. We look at earmarking within ODA, defined as the practice of designating specific revenues to the financing of specific public services through multilateral organisations, but over which the donor retains some degree of control, earmarked for a specific country, project, region, sector or theme.[11 17] This contrasts with 'core' contributions

to multilateral organisations, which are resources transferred to multilateral organisations that the governing boards of these organisations have the right to allocate as prescribed by the organisation's mandate.

Due to high relative dependence on aid, particularly in the health sector, priorities and services established by recipient governments could be affected by donor priorities, even through multilateral institutions.[18] Principal-agent theory considers the relationship between member states (principals) as those that give the mandate and authority to a multilateral (agent) to act on their behalf.[19] Principal-agent theory has sought to understand when and why the agent takes on priorities or interests of the multilateral that depart from the interests of the principals. It is often assumed that multilateral institutions act in the best interests of all members, not simply the most powerful ones.[20] Yet, the increased utilisation of earmarking challenges this assumption, as donor states drive the agenda to suit their political manifestos.

Donor concentration

Lessmann and Markwardt[21] used measures of fiscal decentralisation and political decentralisation based on countries' constitutional rules (at the national level). We consider decentralisation and in turn concentration *at the market level*, examining diversity and relative market share of donors as opposed to recipient contexts. Bird and Aninat suggest concentration may take one of two forms: (1) a lower number of total donors or (2) an increasing share of total donation amounts controlled by fewer donors.[22] However, paucity of data on philanthropic ecosystems has made it difficult study concentration. At the country level, a small number of analyses suggest concentration has increased since the 2008 global financial crisis, but there is minimal research on donor structure during COVID-19. With increasing quality of multilateral and donor data, we examine this issue at the cross-national ODA level.

This builds on microeconomics theorising and codifying dynamics created by the concentration of suppliers (eg, monopoly, duopoly, oligopoly) or buyers (eg, monopsony) and how they create power imbalances between actors.[23] In the case of ODA, donors can be viewed as suppliers (ie, providers of social investment capital) or, at times, buyers (ie, purchasers of the private production of public goods and anticipated social impact). ODA donor concentration would suggest clear leverage over countries receiving aid. As with national philanthropic contexts, to secure financing, countries may in turn become more likely to sacrifice their core strategic goals to serve donor objectives.[22] This is relevant in the context of non-COVID-related health efforts, particularly efforts to strengthen health systems and in line with efforts to achieve UHC and related SDGs. We consider lack of, or difference in, access to ODA resulting from concentration of capital in the 'donor market' which may manifest as a power imbalance between actors in the philanthropic ecosystem (resource dependency). This provides a framework for exploring trends in the ODA ecosystem. This form of concentration may have several consequences for health system strengthening, sustainability of domestic health structures and indeed global health governance.

Table 1 Financing instruments used in distributing multilateral aid

Vehicle	Description
Grants	Grants are transfers made in cash, goods or services for which no repayment is required.
Concessional loans	Transfers for which repayment is required, but extended on terms substantially more generous than market loans. Such concessions can be achieved through: ► Interest rate: per cent per annum—often below those available on the market. ► Grace period: flexibility in the interval from commitment date to the date of the first payment of amortisation. ► Maturity: the interval from commitment date to the date of the last payment of amortisation, with periods of up to 30–40 years. ► Discount rate: the methodology used to determine the present value of future payments. Concessional loans generally include interest rates below those available on the market, by grace periods or a combination.
Non-concessional (market) loans	Transfers for which repayment is required. Only loans with maturities of over 1 year are included in DAC statistics. Data on *net* loans include deductions for repayments of principal (but not payment of interest) on earlier loans. This means that when a loan has been fully repaid, its effect on total net ODA over the life of the loan is zero.
Non-export credit	Loans for the purpose of trade and which are not represented by a negotiable instrument. They may be extended by the official or the private sector. If extended by the private sector, they may be supported by official guarantees.

DAC, Development Assistance Committee; ODA, official development assistance.

Aid modality

For aid modality, we examine financing vehicles. The most flexible financing vehicle (from donor to recipient) is an unconditional grant, the direct provision of money or other goods with no anticipation of repayment or oversight over expenditure (table 1). Non-concessional

loans represent a less flexible modality, where repayment is required based on market rates. Each aid modality has benefits and drawbacks. MDBs have enforcement capacity that allows international debt markets to function more efficiently.[24] As a result, loans may allow poorer governments to borrow more than they otherwise could; in theory expanding a country's debt capacity. In addition, repayments on loans to middle-income countries generate profits that are used to help developing countries by allowing for greater concessions on those loans.

However, in cases where official lending expands a low-income country's borrowing capacity, it may also commit that country to repayment levels beyond what would reasonably be supported.[24] Better credit access to finance public goods, such as public infrastructure projects, may come with an increased risk of debt distress where repayment commitments over time may outweigh gains. Additionally, by making loans that are large in financial volume and long term, development banks can obtain a unique degree of leverage over developing country policies.[24] Countries with routinely compromised national capacity may be prone to serial default. In cases of exogenous shock, such as COVID-19, short-term pressure to borrow may eclipse long-term debt risks. Just as aid is arguably more effective in countries with strong institutions,[25] so too is expanded debt capacity.

METHODS

Data and study population

We examined data on aid inflows and outflows reported by countries and aggregated annually. The primary source for this was the 'OECD-DAC' database, overseen by the Development Assistance Committee (DAC) and provides donor flows through the Creditor Reporting System.[26] DAC members report annually to the DAC secretariat official development assistance (ODA), other official flows and private funding (foreign direct investment, bank and non-bank flows) to developing countries. The DAC secretariat is responsible for processing and disseminating the data.[27] We examine aid from all formal donors and to all DAC countries and territories eligible to receive official development assistance (ODA). Our primary focus was official multilateral donors.[26] These included UN institutions, such as WHO and Joint United Nations Programme on HIV/AIDS (UNAIDS); Bretton Woods institutions, such as International Monetary Fund (IMF) and WBG; and regional development banks (RDB), such as the Asian Development Bank (ADB).

Approach

We first show major international donors' core mandates and ODA amount disbursed, in US$ 2020 constant prices, for both 2011 and 2021. We then examine ODA disbursements over time, also in 2020 constant prices from 2010 to 2021; parsing apart the share of inflow provided for core programming and those that are earmarked. We define earmarking in line with the OECD-DAC 2020 technical brief: *Earmarked Funding to Multilateral Organisations: How is it Used and What Constitutes Good Practice?*,[28] including (1) country-specific programmatic funding; (2) global or regional programmatic funding; (3) country-specific project-type funding; and (4) global or regional project-type funding (online supplemental table 1).[28] Project-type earmarked contributions are resources strictly earmarked for a specific use, at the project level, leaving no, or limited flexibility to the recipient organisation on allocation.[28] Programmatically earmarked contributions are resources that are earmarked with a greater degree of flexibility. These resources include contributions to specific purpose programmes and funds managed by implementing partners, as well as contributions to basket funds/pooled funding.[28] We plot share of inflow that is earmarked within multilateral against their average annual financing volume. Average financing volume is defined as the average gross disbursement of ODA in 2020 constant prices from 2010 to 2020. We generate an R-squared to assess the relationship between financing volume and earmarked inflow. We also look at earmarked contributions by sector for the multilateral system in 2019 and 2020, producing a simple measure of change.

Second, we assess multilateral market characteristics defining the market as all official donors with a multilateral designation (UN and non-UN) within the OECD-DAC database. We assess market diversity with two measures created to evaluate species diversity: the Shannon-Weiner Function and Gini-Simpson Index. Shannon-Weiner is based on randomness present within a given market (or ecological site) and considers both 'richness', that is, number of actors (or species), and equitability in their distribution.[29] The Gini-Simpson Index is the probability that disbursed aid will originate from different multilateral actors; the higher the value, the higher the diversity.[29] To assess concentration, we calculate a Herfindahl-Hirschman Index (HHI). The HHI is obtained by taking the sum of squares of the shares of each donor's ODA each year. For all measures, ODA is measured as disbursed assistance in US$ 2020 fixed purchasing power parity. HHI values range from 0 to 10 000, with an HHI closer to 0 indicating a more 'competitive' market and closer to 10 000 indicating a less competitive market, or monopoly.[30] Using this methodology, official donors are treated as 'market actors' to generate a measure of market concentration for each year. We first calculate an HHI with each officially listed donor as a separate entity and then again including trusts (ie, Global Fund *within* the WBG). Trust funds are resources contributed voluntarily but held separately from a core budget.[31 32] Finally, we examine financing vehicles used to disburse aid (table 1). Specifically, we look at 'grant share' of total ODA from all formal donors over time; table 1 provides an overview of non-grant vehicles included in the denominator.

We further conducted an annotated bibliography of currently available peer-reviewed and grey material concerning the impacts of COVID-19 on aid recipient

settings and international aid flows. We identified relevant sources from searches within Google Scholar, Web of Science (refining by development studies) and available grey and original source materials. We employed a thematic saturation approach, not fully comprehensive, but an illustrative overview of sources that summarise key issues of the debate. Due to the use of highly aggregated country-level and institution-level data, this study did not involve patient participation. In addition, ODA data cannot be disaggregated at a subnational level, which prohibits a more granular understanding of disbursement for different populations.[33]

RESULTS

Looking at multilateral entities providing ODA, we first examine the amount each multilateral disbursed in total ODA, showing the top five multilaterals across three categories: UN, non-UN multilaterals and RDBs (table 2). Examining trends in ODA over time, in 2020 US$ constant prices, we see high variability from year to year (not shown) but a steady increase in multilateral ODA over time. We observe a $31 425 million increase in multilateral ODA (gross disbursements) from 2011 to 2021 across all three categories. Non-UN multilaterals contributed most both in absolute and relative terms: with approximately $41 000 million disbursed in 2021 (+20 273 million, from 20 953 to 41 226). UN multilaterals and RDBs both disbursed approximately $5000 million in 2021, with RDBs representing a more significant increase ($2899 million) from 2011. Of RDBs, the ADB disbursed the most at $3049 million in 2021, an order of magnitude lower than the highest non-UN multilateral, the WBG at $29 913 million.

We find that the earmarked share of contributions to multilateral entities has been rising steadily over the past decade (figure 1), whereas core contributions have remained constant. General, core multilateral contributions (based on gross disbursements) increased by approximately 7% (+7.3%, from 29.9% to 37.7%). This aligns with a broader increase in overall multilateral inflows from just over $50 billion in 2012 to nearly $80 billion in 2020; with most of the increase composed of earmarked funds. This increase, and the concurrent increase in the share of multilateral contributions earmarked at the global or regional level, may reflect an increase in global financing mechanisms in the form of managed trusts, such as the COVID-19 Response and Recovery Trust Fund.[11]

In line within findings from the OECD, we see that the share of DAC members' non-core (earmarked) contributions in their total ODA is channelled through the multilateral development system and earmarked for specific objectives; core functions are receiving less funding proportionally.[11] Looking at this by UN entity (figure 2), we see that the WHO, the UN agency tasked with the directing and coordinating authority on international health, has one of the highest rates of earmarked inflow (74%). While the WHO has a large average annual financing volume as compared with other UN agencies, we observe a positive and statistically significant relationship between financing volume and the share of inflow earmarked (R^2=0.272, p<0.05).

Looking at *how* inflow is earmarked (table 3), we see an increase in earmarking for social programming (online supplemental table 2) but decreases in humanitarian ODA and ODA related to governance. The social sector, which comprises health and social protection measures, had an increase in earmarked contributions from DAC members between 2019 and 2020 (+5.6%, from 18.5% to 24.1%). This increase was largely driven by a rise in contributions earmarked for health and other social infrastructure. Conversely, the focus on COVID-19 appears to have crowded out financing to some other health-related issues, such as disaster prevention (humanitarian) and rural development.

Regarding multilateral market concentration, we observe an increase in total multilateral actors from 2011 to 2021 (table 4). This corresponded with an increase in both measures of diversity: an increase in the Shannon-Weiner Function (+0.422, from 3.258 to 3.680) and the Gini-Simpson Index (+0.012, from 0.962 to 0.974), indicating increased market diversity. However, we find the HHI for the multilateral market increased by 391 from 2011 to 2021 (+391, from 1132 to 1523). This suggests higher market concentration in 2021 than prior to the onset of the COVID-19 pandemic, with the WBG making up 37.4% of all funding disbursed (compared with 32.5% in 2011). When including trusts as part of their managing entities (model II), the HHI is higher in every year with a more pronounced increase from 2011 to 2021 (+1366, from 2756 to 4122). Increases in the HHI indicate a decrease in competition and an increase in market power. The HHI results for model I suggest the ODA multilateral marketplace would be categorised as an 'oligopoly' or moderately concentrated with a small number of actors all serving as influential players. However, when accounting for trusts, it is a highly concentrated market (all values over 2500). After the WBG, the donor entity with the second highest market share in 2021 (excluding trusts) was the IMF at 5.0%, whereas RDBs made up only 7.0% collectively, of which the ADB disbursed the highest absolute amount of ODA with a market share of 3.8%.

In examining trends in grants versus loans (figure 3), we find a decrease in grants as a share of all ODA commitments from multilaterals at 54% in 2020 (−14%, from 68% to 54%). This trend coincides with a rise in non-UN multilateral agencies' share of the multilateral marketplace. However, in looking more granularly at funding from the WBG, we see an increase in the share of ODA provided as grants for social sector programming, which includes health and population-related ODA, over time (+16%, from 19% to 35%).

The increase in multilateral ODA in the form of loans that we observe coincides with a growing number of low-income countries that are at risk of debt distress. Rates of

Table 2 Top UN, non-UN and regional development bank multilaterals providing official development assistance (ODA)

	Summary of core mandate	Year founded	Headquartered	ODA outflow 2011	ODA outflow 2021	Change (US Millions)
				US$ millions, 2020 constant prices		
Multilaterals total				48 471	79 896	+31 425
United Nations (UN)				4736	5033	+297
UNICEF	Ensure every child is protected, healthy and educated, focusing on the children left behind by wider economic and social progress.	1946	New York	1046	857	−189
United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA)	Provide assistance and protection to Palestine refugees pending a just and lasting solution to their plight.	1949	Amman	576	687	112
International Fund for Rural Development (IFAD)	Combat rural poverty by mobilising and providing financial resources on concessional terms for agricultural and rural development projects.	1977	Rome	829	626	−203
WHO*	Act as the directing and coordinating authority on international health work.	1948	Geneva	428	576	148
UNDP	End poverty, build democratic governance, rule of law and inclusive institutions.	1965	New York	468	407	−61
Non-UN multilaterals				20 953	41 226	+20 273
WBG	End extreme poverty within a generation and boost shared prosperity.	1944	DC	15 751	29 913	+14 162
Global Fund	Reduce infections, illness and death, mitigating the impact caused by HIV/AIDS, tuberculosis (TB) and malaria.	2002	Geneva	776	6436	+4051
IMF	Further international monetary cooperation, encouraging the expansion of trade and economic growth and discourage policies that would harm prosperity.	1944	DC	1378	3988	+2610
GAVI, the Vaccine Alliance	Save lives and protect people's health by increasing equitable and sustainable use of vaccines.	2000	Geneva	776	1607	+831
Central Emergency Response Fund (CERF)	Enable timely and reliable humanitarian assistance to people affected by disasters and emergencies.	2005	–	–	518	–
Regional development banks				2810	5687	+2877
ADB	Promote a prosperous, inclusive, resilient and sustainable Asia and the Pacific, while sustaining efforts to eradicate extreme poverty in the region.	1966	Mandaluyong	2170†	3049	+878
Central American Bank for Economic Integration (CABEI)	Support the Central American countries in their efforts to achieve new phases of economic development and better opportunities for well-being.	1960	Tegucigalpa	–	1997‡	–
AfDB†	Promote economic and social development across all of Africa. Primary mission is to reduce poverty.	1964	Abidjan	2347	1718	−629
Inter American Development Bank (IADB)	Improve lives in Latin America and the Caribbean through financial and technical support for countries working to reduce poverty and inequality.	1959	DC	2021§	545	−1476
Islamic Development Bank (IsDB)	Mobilise and use resources for the economic and social progress of its member countries as well as Muslim communities in non-member countries.	1975	Jeddah	346	234	−112

For each category, the five entities with the highest ODA outflow in 2021 (gross disbursement as reported within the OECD-DAC database) are included.
*The WHO-Strategic Preparedness and Response Plan (SPRP) reported an additional outflow of US$151 million in 2021.
†Includes both the African Development Bank and the African Development Fund.
‡CABEI outflow value from 2020.
§ADB and IADB estimates from 2012 as opposed to 2011.
ADB, Asian Development Bank; IMF, International Monetary Fund; OECD-DAC, Organisation for Economic Co-operation and Development's Development Assistance Committee; UNDP, United Nations Development Programme; WBG, World Bank Group.

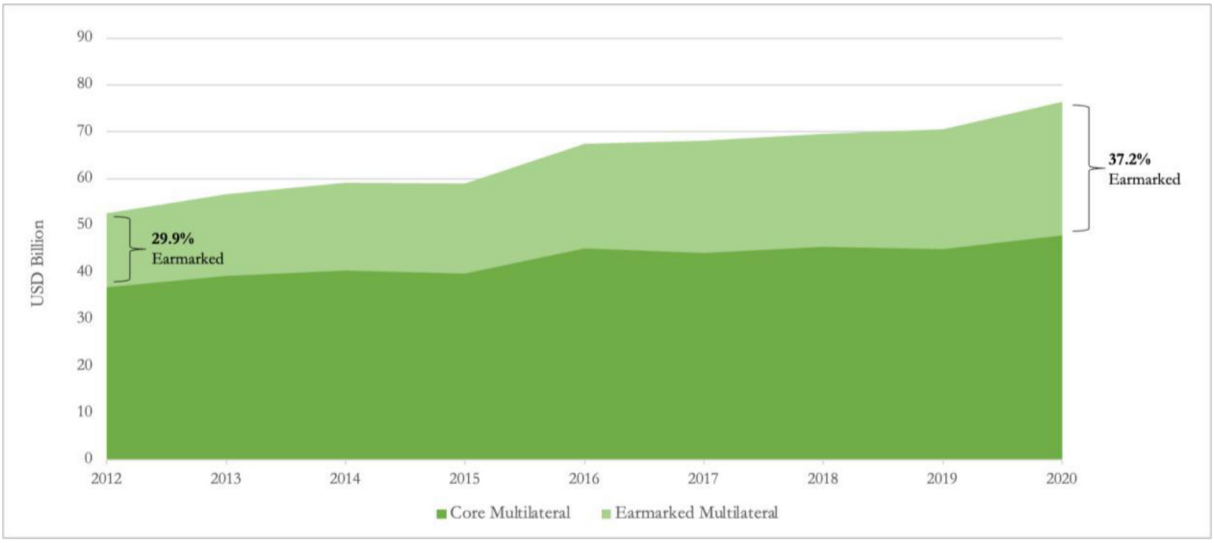

Figure 1 Multilateral official development assistance (ODA) inflow from 2012 to 2020 core and earmarked. Funding to the multilateral development system by year in US$ billions; data label percentages represent share earmarked out of total multilateral inflows in a given year (ie, 2012 and 2020).

indebtedness are unprecedentedly high for non-conflict periods with 90% of low-income countries designated as moderate, high or distressed regarding risk of debt distress (online supplemental figure 1).

This work is subject to several limitations. First, we do not attempt to make causal claims or attribute changes in ODA to the pandemic. As the OECD has noted, that the pandemic period did not correspond with a more significant deviation from previous trends suggests the existence of rigidities and path dependencies that constrain the ability of DAC members to swiftly adjust and balance ODA allocations. Second, the functional attributes of ODA that we examine are inherently limited by data availability. For example, while earmarking is one mechanism to exert donor prioritisation, as demonstrated by Khan *et al*, donors influence recipient counties

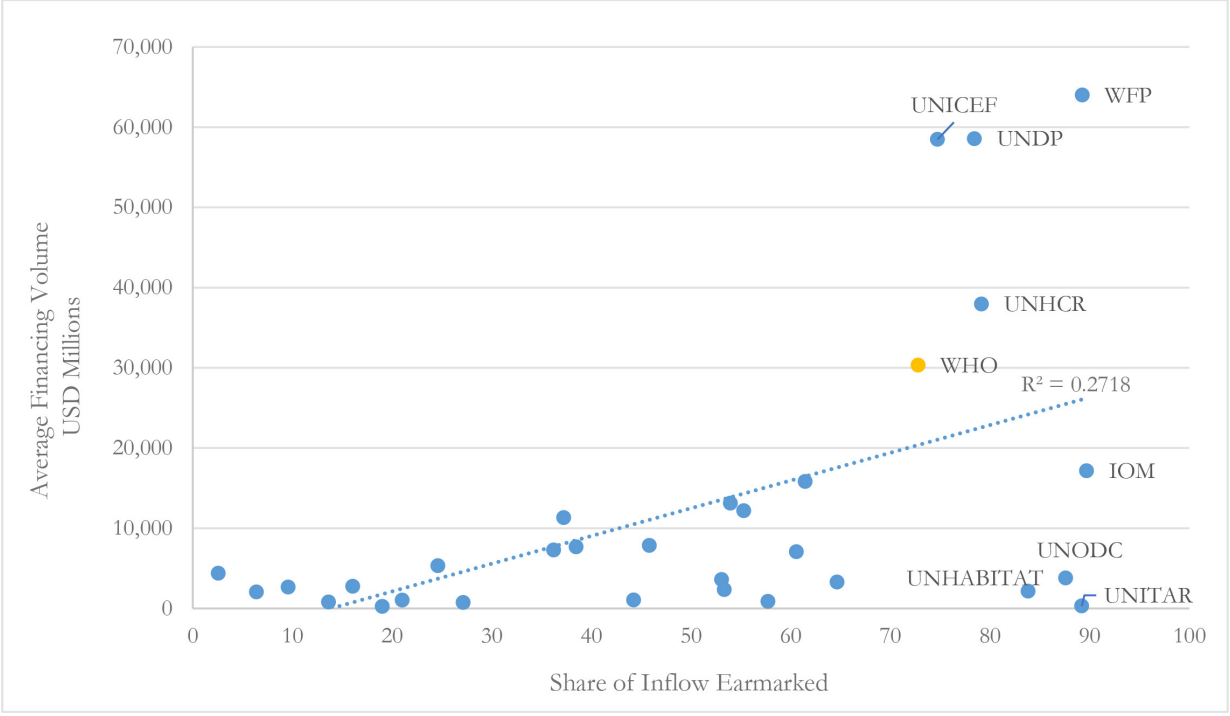

Figure 2 Share of United Nations (UN) entity inflow earmarked by entity's average financing volume. Average financing volume is the average gross disbursement of official development assistance (ODA) in 2020 constant prices from 2010 to 2020, UNDPO and core UN excluded. UNDP, United Nations Development Programme; UNHCR, United Nations High Commissioner for Refugees; UNITAR, United Nations Institute for Training and Research; UNDPO, United Nations Department of Peace Operations.

Table 3 Change in earmarked contributions by sector in US$ billions 2019 vs 2020

	2019	2020	Change
Humanitarian	44.8	38.6	–6.2
Social	18.5	24.1	5.6
Governance	14.0	10.9	–3.1
Multisector	8.2	7.9	–0.3
Production	6.1	8.4	2.3
Infrastructure	4.6	5.4	0.8
Other	3.9	4.7	0.8

Calculations based on gross disbursements, 2020 constant prices.

at multiple stages within health policy processes, such as priority setting, policy formulation, policy implementation and monitoring and evaluation.[16] Even when reducing conditionality, donors may employ alternative strategies to influence national policy.[34] As a result, donor priority setting must be understood within the context of more entrenched norms of donor–recipient relations.[16] Third, the data we use for this paper are highly aggregated at the national-annual level. While this allows for cross-donor comparison—is also means we cannot examine more granular issues, that is, allocative fairness of earmarked ODA within a country. Fourth, there is limited, or incomplete, information on trusts and we may undercount the role of these funds.[32] Finally, China is not a member of the DAC and does not report into the OECD-DAC or other international aid repositories.[35] However, China does hold approximately 6% of shares of the ADB and just short of 27% of shares for the Asian Infrastructure Investment Bank.[36]

DISCUSSION

Aid disbursement from multilateral institutions increased significantly at the onset of COVID-19. Yet, functionally, we find ODA from multilaterals is mimicking the attributes of bilateral aid. This was borne out in three important, although not comprehensive, areas during COVID-19: (1) an increasing prevalence of earmarking of aid inflows to the multilateral system; (2) higher concentration of the donor 'market' driven by the WBG; and (3) a rise in loan-based disbursements. While the absolute number of multilateral actors has been increasing since 2012, and in turn market diversification, there has been a concurrent consolidation led by the WBG at 37% of market share in 2021; and just under 50% if we consider trusts held by the WBG. Consolidation may streamline revenue pooling and, in theory, allow for a more collective approach to achieving global development goals, but prioritisation exercised through increased earmarking also has the potential to sideline counties' democratic manifesto pledges and orient ODA towards donor-driven priorities.

While we explore the role of earmarking as it relates to donor control,[37] we recognise the use cases *for* earmarked funding. For example, earmarking can be used to protect high-priority programmes or issues from budget cuts, or shifting political content—such as support for HIV/AIDS-related programming.[17 28] In addition, this may generate support from donors that would otherwise not be allocated to ODA, the proceeds of which can be used for broader system-wide health provision and strengthening, such as occurs in the Global Polio Eradication Initiative. However, the overarching argument against excessive earmarking is that it *explicitly* removes power from recipient countries to control their own health

Table 4 Diversity and concentration within the multilateral official development assistance (ODA) 'Market' 2011–2021

		Market diversity		Market concentration		WBG share	
Year	Market actors	Shannon-Weiner Function	Gini-Simpson Index	HHI model I	HHI model II*	WBG share without trusts (%)	WBG share with trusts (%)
2011	33	3.258	0.962	1132	2756	32.5	39.2
2012	38	3.434	0.968	751	2021	25.3	33.9
2013	39	3.466	0.969	699	2039	23.6	34.3
2014	39	3.466	0.969	1238	3223	33.7	42.9
2015	41	3.526	0.971	893	2789	26.7	41.0
2016	42	3.555	0.971	655	1945	23.8	33.8
2017	45	3.638	0.974	1317	3235	35.4	42.6
2018	44	3.611	0.973	1263	3089	34.1	41.6
2019	46	3.664	0.974	928	2896	28.3	41.4
2020	50	3.761	0.977	1360	3132	34.5	41.0
2021	48	3.680	0.974	1523	4122	37.4	49.7
Change	+15	+0.422	+0.012	+391	+1366	+4.9	+10.5

*Herfindahl–Hirschman Index (HHI) model II treats trusts (eg, the Global Fund) held by a given entity (eg, the World Bank Group) as part of the holding entity. This contrasts with model I, which treats each official multilateral donor within the OECD-DAC as a separate entity.
OECD-DAC, Organisation for Economic Co-operation and Development's Development Assistance Committee; WBG, World Bank Group.

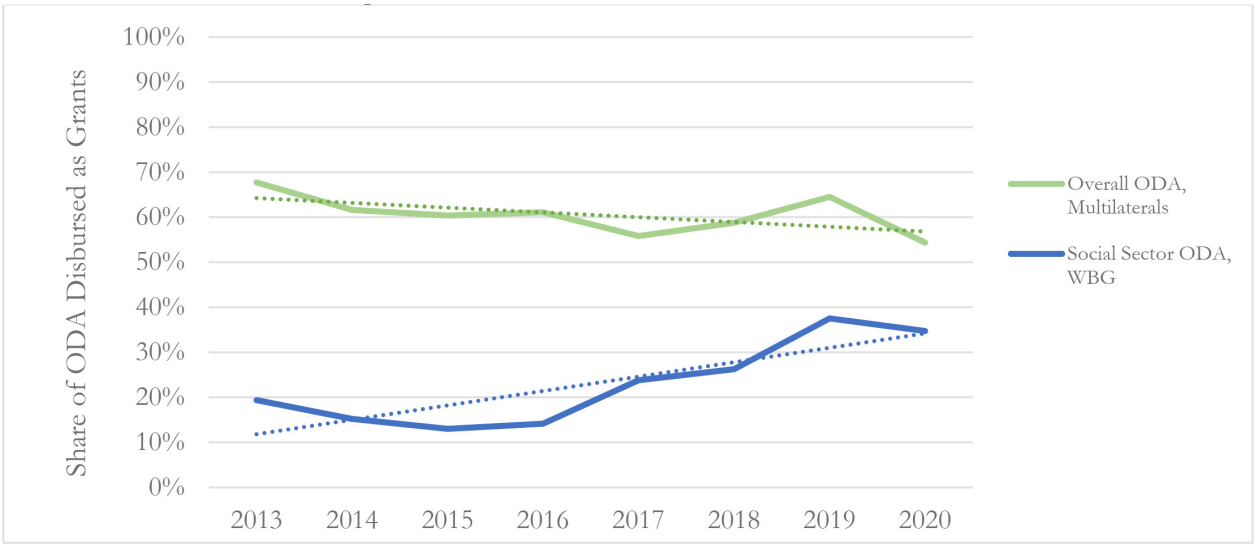

Figure 3 Grant share of total official development assistance (ODA) among all multilaterals and social sector World Bank Group (WBG) ODA.

and/or development programmes.[17] Moreover, donor-driven initiatives through earmarking contributions tend to prioritise vertical interventions that can be easily measured using standard performance metrics, often in contrast to more horizontal, system-based or rights-based approaches to health.[38] This may include the number of bed nets delivered or antiretrovirals administered at the cost of broadened system-strengthening health activities, such as workforce capacity building.[38]

In addition, if we think of earmarked contributions to multilaterals as eclipsing core contributions (ie, zero-sum, at least in relative terms), this could lead to a gradual erosion of critical functions relevant to global health governance. Providing strategic and long-term oversight of key reforms requires cross-national coordination and adapting to the evolving and expanding nature of global development challenges.[14] This is all too real for the WHO, which as an institution only controls approximately 20% of their budget. The remaining ~80% comes in the form of earmarked funding from a small number of state and non-state donors, with donor-determined projects resulting in a contracting-like dynamic. The result has been described as a vicious cycle: if countries do not trust the WHO to effectively deliver on core mandates, they increasingly turn to earmarked contributions where they can further national health-related development goals.[39] Recent reforms at WHO have sought to increase the assessed contributions of WHO both in real terms, and as part of their overall budget share.[40] While these have been agreed in principle, it is unclear whether member states will adhere, given historical actual financing deficits, and how this might alter earmarking.[41] While the OECD has recently sought to standardise accounting practices for earmarked contributions, there is a pressing need to be candid regarding impact on institutional authority.[28] In addition, the measures used in this piece are highly aggregated. In reality, there is a more complex landscape of aid contingencies with inflexibility (eg, directly delivered technical assistance) to more flexible allocation (eg, budget support).[17]

The argument for multilateralism has often centred liberal democratic principles of governance, including transparency, representation and participation. Yet, the growing prevalence of earmarking in multilateral aid suggests a less rigid distinction between bilateral and multilateral ODA, the major concern (in both cases) is that someone other than the recipient is deciding how aid should be allocated. Bird and Aninat categorise concentration in the following forms: (1) a lower number of total donors or (2) an increasing share of total donation amounts controlled by fewer donors.[22] We find there has been an increase in the absolute number of official donors over time, as evidenced by the proliferation of actors in global health,[42 43] but a simultaneously more concentrated marketplace in terms of the volume of aid controlled by fewer actors. This could be viewed as the worst of both scenarios: as the number of entities increases, each controls a very small share of the market, leading to fragmentation of financing, governance and authority; and simultaneously increasing concentration provides large funders with undue influence in public goods creation.[22] This is particularly notable for the WBG, who has a controversial history in global health provision, and whose governance is linked to that of the US government.[34 44] Indeed, unlike the governance and decision-making model in the World Health Assembly, based on one state, one vote, decision-making in the WBG is determined by financial contribution. In addition, our estimates regarding concentration are more stark when taking into account the WBG's trusteeship of entities, such as the Global Fund and GAVI the Vaccine Alliance.[32] These relationships may provide a veneer of diversification across the sector, but in practice demonstrate greater consolidation. The WBG helped set up both institutions

and remains a major financial supporter, serving as board member for both GAVI and the Global Fund, as well as fiduciary agent, financial and treasury manager of GAVI. As such, the WBG maintains considerable influence over the activities of these institutions.

On the surface, increased ODA disbursements from multilateral actors are something to be lauded during a pandemic: meaningful commitments for managing transnational health issues. Yet, the data demonstrate an outsized, and increasing, role of certain actors, which merits re-examination after pandemic. A stark example is the increasing role of the WBG in global health governance in contrast to the WHO, which is the institution mandated to direct and coordinate international health work. Principal-agent theory is one lens through which to consider the WBG's increasing market share: principals may be less willing to give power to multilateral agents they deem ineffective and in turn take steps to maintain control of their ODA funding or target funding to agents deemed effective, for example, the WBG and its trustee institutions. While allocation to trusted agents is rational, these data come midst broader efforts to decolonise global health motivated by complex and long-standing power dynamics. Despite these efforts, trends in ODA suggest development and health governance increasingly sit with the WBG and in turn the USA.[45] The perceived effectiveness of GAVI and the Global Fund may incentivise national investments that would otherwise not be allocated towards ODA. However, consolidation more broadly demonstrates the concentration of power within global health governance.[46] States that do engage in ODA increasingly appear to do so when they are able to dictate terms (ie, earmarking), potentially due to the ability to demonstrate meaningful results for their own electorates.

Moreover, WBG dominance specifically raises specific concerns for internal governance and debt. First, WBG has historically approached health from a development perspective, whereby health is largely seen as a mechanism for achieving production value within labour markets.[47] Health may, in turn, be treated as a commodity, rather than a right, informing concepts such as human capital, cost-effectiveness and disability-adjusted life-years,[48] each of which ascribe value to health as it relates to labour force contribution.[49] Second, the governance model employed *within* the WBG challenges accepted liberal democratic norms of governance: voting at the WBG is not one state, one vote as seen elsewhere in the global health architecture, but determined by volume of financial contribution.[44] The US government has the single largest voting share, can veto any major decision and always appoints the president of WBG through an unwritten agreement. For many, this makes WBG a proxy of the US government, challenging independent health and development policy where the most prolific principal actor is in effect simultaneously a proxy agent.[50] Third, WBG has been widely criticised for its role in global health programmes over the last half century. For example, structural adjustment programmes have 'set back healthcare in low and middle income countries more in one decade than anything states themselves could have done since colonialism'.[51] Compounding these issues is an enduring and historically contentious issue regarding how aid is distributed. Reliance on loans means that many countries entered the pandemic in debt. While the WBG does adjust future financing from loans to grants for countries at high risk of debt distress (and an increasing share of the WBG's social portfolio distributed in grants) offers some promise, this approach will be tested as more countries enter debt distress (online supplemental table 3).[52]

CONCLUSION

COVID-19 confirmed the significant role of multilateral ODA in times of global crisis. However, the data presented in this paper highlight the importance of looking beyond aggregate disbursements and examining the changing nature of ODA: an increase in earmarking, decrease in grant-based disbursements and a larger, though more concentrated, donor landscape. These findings raise important questions regarding global health governance and the ability to respond to global crises. For example, many governments departed from their financial and legal obligations to UN institutions.[53] After pandemic, we have the opportunity to re-examine these systems and the extent to which they align with the promise of multilateral development assistance: a coherent, and representative, set of organisations that can mobilise on shared goals. However, this requires clear examination of how the current system operates, for whom and why.

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