CENTER FOR GLOBAL DEVELOPMENT

The Future of UK Global Health Policy: Challenges and Opportunities

PETER BAKER · LYDIA REGAN

Abstract

Since 2019, the UK's strong reputation in global health has been undermined by a series of deep cuts and a distracting departmental reorganisation. 2024 may, however, represent a turning point, with new Foreign and Development Ministers, both with a strong track record on development, the implementation of a new development white paper, and a possible election which may bring a new government with new priorities. In this paper, we summarise the challenges and opportunities in global health on which the UK will need to act if it wishes to restore its reputation. We review UK global health aid expenditure data up to 2022, current UK global health policies, and major external global trends. We find that in 2018, the UK reported spending £2.17 billion (0.1 percent of Gross National Income (GNI)). By 2022, this fell to £1.73 billion (0.07 percent of GNI). If the UK had continued at 0.1 percent of GNI level, it would now have an additional £844 million to spend on global health annually. Bilateral programmes, Foreign Commonwealth & Development Office-managed aid programmes, and reproductive health programmes were particularly hard hit by the cuts. We identify three global trends that the UK must accommodate: an acute-on-chronic health financing crises in low- and middle-income countries; changing demographics, burden of disease, and increasing global threats; and the inadequacy of global health architecture. Finally, we recommend a five-point plan for the UK government to take forward: 1) Champion debt relief and "health taxes" to increase resources for health; 2) Support countries to strengthen health system efficiency; 3) Prioritise limited UK financing on key, measurable objectives in a few low-income countries. 4) Conduct a multilateral aid review that focuses on developing country priorities; and 5) Direct UK health system strengthening funding through the World Bank and long-term bilateral programmes.

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Introduction

The UK frequently proclaims it has "a proud history of leadership in global health." (1) It has indeed made major contributions in shaping the global health agenda and global health institutions. It was one of the founding members and top contributors of the Global Fund for AIDS, Tuberculosis and Malaria, and Gavi, the Vaccine Alliance; it was instrumental in founding the Scaling Up Nutrition movement; and it remains a top contributor to the World Health Organization. (2) Its reputation is in part based on the scale of its resources—after committing in 2010 to contribute 0.7 percent of GNI to Official Development Assistance (ODA), it rose to be the second largest bilateral contributor of development assistance for health—reaching £2.3 billion per year (0.13 percent of UK GNI). (3) More subtly, its reputation has been based on the expertise of its staff, which has enabled it to input technically into the global health architecture, such as sitting on the Global Fund's Board committees and shaping its 2023 strategy. (4)

However, a series of decisions since 2019 have threatened this reputation, as documented by a recent Independent Commission for Aid Impact (ICAI) review. (5) The first was the cuts to its aid budget to 0.5 percent of GNI in the middle of a global health emergency. The second was the merger of the Foreign and Commonwealth Office and the Department for International Development (DFID) into a new Foreign, Commonwealth & Development Office (FCDO), with the resultant distraction and loss in the positive DFID brand identification. The third was further large cuts to pay for UK-based costs of refugees. These factors, combined with a lack of careful planning of where the cuts fell, caused a fourth challenge—it made the UK an unreliable development partner, with fluctuating budgets that made it hard for both multilateral and bilateral partners to plan and deliver.

2024 offers an opportunity for the UK to begin to restore its reputation. The surge of ODA spent on refugees in the UK is expected to come to an end and there are scheduled reductions in the UK's contribution to the EU's aid budget, both releasing resources that could be used for global health objectives. (6) How this budget will be depends on the result of a possible 2024 general election. Should the Conservatives win, the government will be looking for ways to deliver on the new white paper on international development, led by David Cameron and Andrew Mitchell—both with good track records on development. (7) Should Labour win, it will make space for new approaches, but perhaps no additional funding in the short-term.

Therefore, this paper aims to explore key challenges and opportunities that future governments, whatever their stripes, will need to consider if they want to maximise their contribution to global health over the next five-year parliament. The paper has four parts: the first is a review of UK global health expenditures from 2018–2022; the second identifies three major external global trends that the UK must respond to; the third examines current UK global health policies, and the fourth recommends a five-point plan for the UK to consider for the future.

Methods

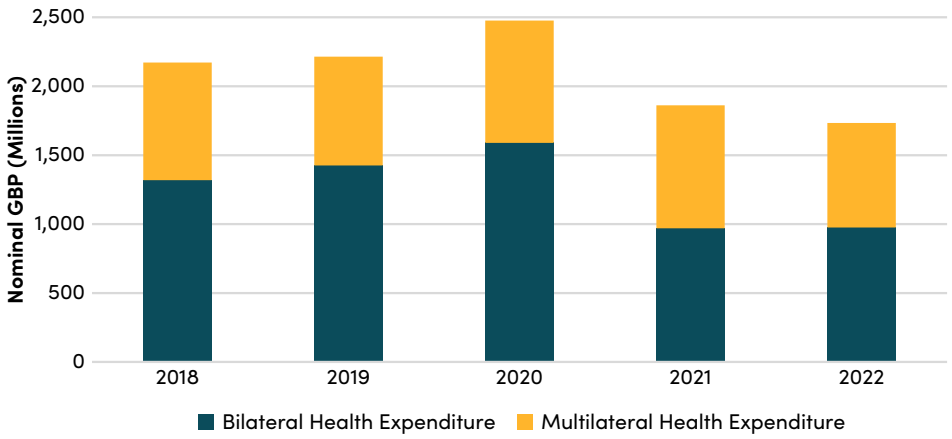
This is a synthesis paper that draws on official UK aid expenditure data (3), UK global health policy papers, other aid agency policies, key reports on global health trends, and interviews with colleagues from Africa Centres for Disease Control and Prevention (Africa CDC), FCDO, Chatham House, Bill and Melinda Gates Foundation, and ICAI. Data was not yet available for multilateral global health expenditure in 2022 and so was estimated based on available information (see Annex A). Initial findings were then discussed with the International Directorate at the UK Department of Health and Social Care (DHSC) to ensure a full range of government perspectives were considered. All views presented in this paper are the authors, and not the interviewees.

Section 1: Review of UK global health expenditures and strategy papers

Trends in UK global health expenditures

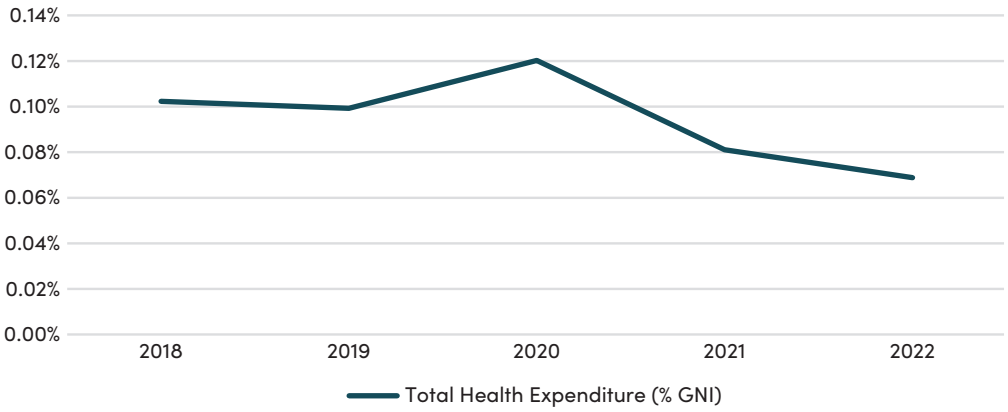
In 2018, prior to the pandemic, the UK reported spending £2.17 billion on global health. This then rose during the pandemic, before falling to £1.73 billion in 2022, representing a 21 percent fall in nominal value over five years (£439 million) (see Figure 1). When adjusting for the size of UK economy, we estimate that in 2018, the UK spent 0.1 percent of GNI on global health, which fell to 0.07 percent of GNI in 2022, a 33 percent fall. This is a slightly greater cut than overall UK aid, which fell 29 percent during this time. This means if the UK had continued at 0.1 percent of GNI level, it would now have an additional £844 million to spend on global health annually (Annex A). This, therefore, represents our best estimate of the annual cost to global health of the recent cuts in UK ODA from 0.7 percent of GNI to 0.5 percent of GNI, plus the large-scale diversion of ODA to funding refugee costs within the UK, which reached a remarkable 38.9 percent of total bilateral ODA expenditure in 2022 (Annex B).

FIGURE 1A. UK reported nominal bilateral and multilateral global health expenditure



Source: Statistics on International Development: Final UK Aid Spend 2022, ONS 2023.

FIGURE 1B. UK reported total global health expenditure as a % of GNI



Note: 2022 multilateral data is not yet published and was estimated based on publicly available data—see Annex A.
Source: Statistics on International Development: Final UK Aid Spend 2022, ONS 2023.

When we look at what has been cut the most, we can see that bilateral expenditure fell particularly strongly by 26 percent (£343 million) and multilateral expenditure was somewhat protected with a smaller 11 percent fall (£96 million) (Table 1). Within bilateral health programmes FCDO-managed expenditure was cut more (down 32 percent or £336 million) compared with non-FCDO managed expenditure (down four percent or £11 million). There was a notably large 40 percent (£222 million) fall in "population programmes & reproductive health services", which is primarily family planning and reproductive healthcare (for more details on bilateral aid spend, see Annex B).

TABLE 1. Total UK global health aid expenditure 2018–2023 (£m)

	2018	2019	2020	2021	2022	% Change 2018–2022
Bilateral	1,319	1,426	1,589	970	976	–26%
Multilateral	854	789	888	892	758	–11%
Total	2,172	2,215	2,477	1,861	1,734	–20%
Total as % of GNI	0.10%	0.10%	0.12%	0.08%	0.07%	–33%

Note: 2022 multilateral data is not yet published and was estimated based on publicly available data—see Annex A.
Source: Statistics on International Development: Final UK Aid Spend 2022.

We are not aware of any public strategic decision between 2019 and 2022 to deprioritise bilateral, FCDO, and reproductive healthcare—it may have simply been that large FCDO bilateral budgets were easier to cut. There is perhaps some evidence that this went further than the government wanted, given that the International Development Strategy of 2022, called for a move back towards bilateral spend. (8) The cuts to reproductive health are perhaps the most surprising because the UK has numerous policy documents declaring the importance of sexual and reproductive health and rights. In fact, the Conservative 2019 manifesto sought to *"end the preventable deaths of mothers, new-born babies and children by 2030."* (9,10).

Aid expenditures have also been quite volatile, not only changing year-by-year, but 2020 to 2022 saw further in-year cuts. In 2023, some mid-year increases were provided—all requiring sub-optimal and rapid re-programming. For instance, Afghanistan's budget was cut in February 2023 by £191 million to £60 million—a staggering 76 percent. This resulted in major planned cuts to nutrition, education, and vaccines. But following an equality impact assessment, it was topped back up to £100 million. (11) This volatile approach does not align with the UK's international development strategy's commitment to "patient development" and makes it difficult for partner countries to plan and develop strong health systems.

The overall picture is both of declining expenditure and a lack of clear alignment between strategy and expenditures. Going forward, future trends in UK global health expenditure remain uncertain, but there was hope amongst many interviewees that 2022 represents a nadir and that there will be an increase in 2023 and 2024 as aid spent on refugees in the UK reduces and EU resources are released. Increasing budgets offers an opportunity to (re)strengthen the connection between strategy and expenditure, but the direction this takes will depend on a probable 2024 election.

Section 2: Three major trends in global health

In this section, we describe three major global trends and their implications for UK global health policy: an acute-on-chronic health financing crises in low- and middle-income countries (LMICs); changing demographics, burden of disease, and increasing global threats; and the inadequacy of global health architecture.

An "acute-on-chronic" health financing crisis in LMICs

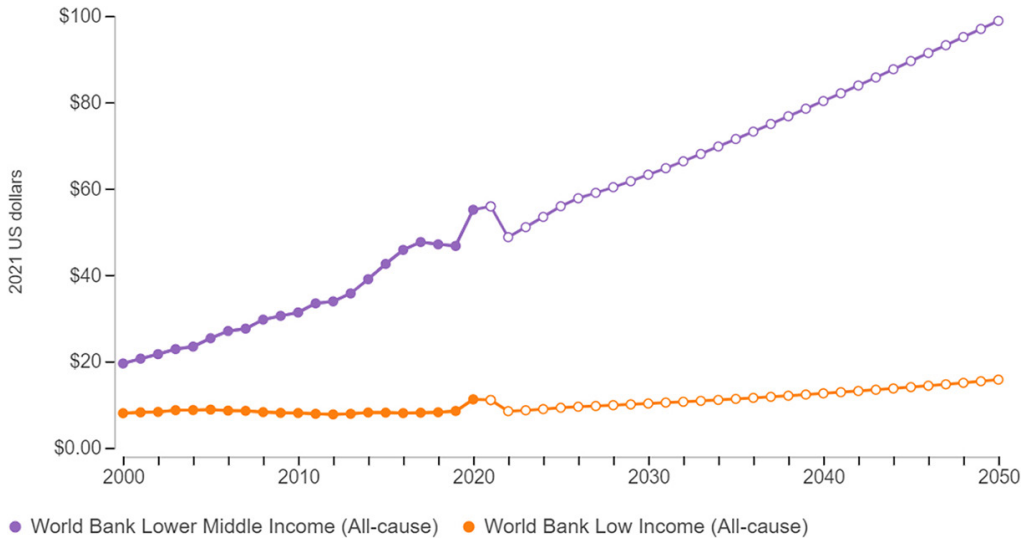
Following the COVID-19 pandemic, Russia's invasion of Ukraine, and the resulting inflation and interest rate rises in high-income countries, LMICs are entering a period of sustained pressure on government finances. According to the International Monetary Fund, global economic growth is significantly slower than in previously periods. (12) 110 LMICs are expected to have similar or lower government expenditure levels in 2027 than in 2019, representing an almost lost decade in raising the resources needed to make progress on the Sustainable Development Goals (SDG) in these countries. (13) 50 countries are spending over 10 percent of government revenues on debt repayments and three billion people live in countries that spend more on interest than health or education. (14)

Going forward, the impact on health financing is not yet known because we do not have health expenditure data past 2020. The Institute for Health Metrics and Evaluation and World Bank projections both suggest that pre-COVID trends will broadly continue into the future, but this may be optimistic given the debt crises (Figure 2). (13,15,16) The problem with returning to pre-COVID trends is that the current acute crisis sits on top of a severe chronic health financing crises, particularly in low-income countries (LICs). While domestic financing for health has been increasing in LMICs it has

been stagnant in LICs since the early 2000s. The Disease Control Priorities project estimates that an essential universal health coverage (UHC) package of services, with 80 percent population coverage, needs approximately US$87 per capita (in 2021 US dollars) for LICs and $143 for LMICs (in 2021), meaning neither group of countries can afford this package right up until 2050. (17)

Future projections are averages and make many challenging assumptions, but with weak growth and constrained government finances in most LMICs, health expenditure can only rise significantly if the level of prioritisation given to health by governments also rises. Indeed, historically there have been cases, such as the UK and Thailand where increased health expenditure did occur in highly constrained post-crises periods. Unfortunately, the current evidence suggests that prioritisation of health in governments did temporarily rise during COVID-19, but then returned in 2022 to pre-COVID levels. (16) Our expectation should therefore be that domestic health financing for health remains relatively stagnant for the medium term *on average*, possibly for the remainder of the SDG era, and that this remains substantially below what is required to deliver a basic package of UHC services.

FIGURE 2. IHME projections of government health expenditure per person 2000–2050 (data past 2020 is forecasted)



Source: IHME Financing Global Health database (15).

Many LICs, particularly in sub-Saharan Africa, remain highly reliant on development assistance for health (DAH) to finance their health sector. The future trajectory of DAH, however, is highly uncertain, not least because it is subject to elections in 2024 in the UK, EU, and US. What is relatively clear, however, is that DAH is unlikely to substantially resolve the health financing crises for two reasons. Firstly, pre-COVID trends of DAH had already become stagnant in 2010. (18) Secondly, the focus on health as a priority sector created by COVID appears to have already waned: the Global Fund and the Pandemic Fund raised less than hoped in 2023, and attention has rapidly shifted to climate

change, wider fiscal challenges, and multilateral development bank reform. Against this challenging backdrop, the UK will need to work with governments—and where possible look for more money for health, or perhaps more realistically, aim for more health for the (same) money.

Changing demographics, burden of disease, and increasing global threats

The world is changing fast. Population growth is concentrated in fewer, poorer countries, resulting in a concentration of global poverty. In 1990, 13 percent of people who were living in extreme poverty lived in the sub-Saharan Africa; in 2022, this has risen to 62 percent, particularly due to economic growth in South and East Asia. (19) In the 60 poorest countries that will remain eligible for Gavi, Global Fund, or World Bank International Development Association (IDA) aid in 2040, we estimate that these countries face a 32 percent population increase, to 2.37 billion by 2040, implying a reduction of aid resources per person. (20)

Demographic, epidemiological, social, and economic changes occurring in almost all countries means non-communicable diseases (NCDs) now result in 74 percent of all deaths globally. Africa is the last remaining region that NCDs do not dominate, but by 2028, the burden of NCDs will overtake communicable diseases. (21) NCDs are challenging because they require more complex, broad-based primary healthcare systems, and careful prioritization due to some very expensive treatment options. For example, renal dialysis alone could potentially consume 15 to 55 percent of total domestic governmental health expenditure in some African countries. (22) NCDs also require wider public health measures—including nutrition, as well as addressing the commercial determinants of health with policies such as taxes on tobacco, alcohol and sugar. (23,24)

Global health *insecurity* is also increasing, with rising threats that require greater global, coordinated action. Pandemics and zoonotic spillover events look set to be more frequent, antimicrobial resistance (AMR) continues to grow, and climate change poses a risk to health through extreme weather events, heat stress, air and water pollution, food system dysfunction, vector-borne diseases, and wider social mechanisms, such as forced migration. (25,26) These topics are also rising up the agendas of most donors and global health institutions, therefore the UK must respond both to the changing epidemiology and the changing pressures on the global health architecture. However, just because they are global challenges, it does not mean that they are necessarily LMIC priorities. Indeed, while it is true that health system strengthening is good for global health security, it is also true that top LMIC priorities for health systems (e.g., basic primary care treatment of childhood pneumonia and diarrhoea) are different to top global priorities for global health security (e.g., stronger surveillance systems). Therefore, the priorities in this debate depend critically on whose perspective is taken and who is making the decision. It is important for the UK to realise that advancing global security may be in deep tension with localising decision-making in global health, and that it takes steps to manage these tensions in both bilateral and multilateral arrangements. (27)

Inadequacy of global health architecture

Following the COVID-19 pandemic, there is growing view that the current global architecture is not fit for purpose: pandemic preparedness lacked an effective mechanism for adequate global financing and coordination, global governance was slow to respond to COVID-19 as it emerged, and the global COVID vaccine rollout was deeply inequitable. (28,29) This latter perspective has triggered many aid-recipient countries to join with Africa CDC and call for a new public health order, with self-sufficiency and localisation (or regionalisation) at the heart of decision-making in global health. (30)

This localisation agenda, in combination with the rise in NCDs, the increasing global threats, and the shift towards health system strengthening (HSS) approaches in global health has also challenged the major global health initiatives (GHIs) that channel global health aid, such as Gavi and the Global Fund. These initiatives have been very successful in resource mobilisation and achieved remarkable successes in their areas, but are not currently well designed to support HSS, nor do they have a clear remit on rising NCDs or global threats. The Future of Global Health Initiatives (FGHI) process, led by senior officials from Norway and Kenya, found these recent challenges lay on top of many stakeholder concerns regarding the GHI's tendency to fragment systems and distort domestic priorities. (31) The UK is very involved in the FGHI process and is direct about the need to reform GHIs. For instance, the UK's Global Health Framework notes that the UK will *"explore their potential evolution in the face of the changing global health landscape."* Indeed the UK's contribution to the 2022 Global Fund replenishment was delayed and smaller than previous rounds, suggesting some internal wavering of support. (32)

Indirectly, but perhaps equally important, the World Bank's Evolution Roadmap and its launch of the Pandemic Fund are re-shaping its future in the global health architecture. (33) Going forward, it will likely be more influential and will have a very clear mandate to work across pandemic financing, HSS, AMR, and climate, making it unique in the global health architecture. The UK has recently cut support to World Bank IDA, and its contribution to the Pandemic Fund is relatively small, which are two decisions that do not appear to be in line with stated strategies. (34)

Section 3: Current UK global health policies

The UK continues to prioritise global health in its overarching development strategies. The 2022 Strategy for International Development, Integrated Review Refresh 2023, and the recent development White Paper all place global health—and particularly global health security—as a major national priority. (7,8,35) Supporting these strategies the UK has released a range of health policies in the last two years, including a 2023–2025 Global Health Framework by FCDO and DHSC and the much-anticipated FCDO Health Systems Strengthening for Global Health Security and Universal Health Coverage position paper in 2021. (1,36) These papers are impressive in their scale, scope, and nuanced approaches to current major challenges. In this section, however, we argue that to have

their desired impact, they need to be clearer on the top priorities; they need a mechanism to allocate financing to these priorities and track progress; and they need a broader conceptualisation of the UK's comparative advantage.

The Global Health Framework articulates four priorities: strengthen global health security, reform the global health architecture, strengthen health systems, and advance UK leadership in science and technology. The first three are broad and expected areas, and are also included as major themes of the EU and French global health strategies. (37,38) This breadth, however, represents an important challenge with UK global health policies. Both the global health framework and the Health Systems Strengthening (HSS) position paper are so wide ranging and ambitious that they do not clearly articulate priorities. Perhaps more importantly, they do not deprioritise. For example, the global health framework's HSS section takes the reader through a dizzying array of priorities—primary health care, gender equality, climate change, nutrition, research and development on farming crops, water and sanitation, and funding through Gavi and the Global Fund. Similarly, the HSS paper has thirteen focus areas. This results in a problem—if everything is a priority, then nothing is—and the policies lose their ability to guide programming. This is a particularly acute challenge in the context of the UK's declining influence in, and budget for, global health. For the US or EU, it may make sense to consider impact on all aspects of global health, in all LMICs. But the UK needs to openly recognise its limits and focus its efforts where it can have the greatest impact.

The HSS position paper then goes deeper into this important area. It is impressive; comprehensively articulating the justification for HSS and the approach that FCDO will take. It puts forward a strong case that HSS is needed for longer-term sustainable impact on health, for empowerment of national governments, as a prerequisite for global health security, and for resilience against many of the upcoming challenges we articulated section two. The need to support countries to get value for money from their health budgets through evidence-informed priority setting of health services is mentioned repeatedly, something CGD has been championing for the last decade through the international Decision Support Initiative (iDSI). (39) Whilst the position paper has many strengths, it is very hard to know if it has altered FCDO's programming, as there are no indicators that are regularly tracked. The second challenge is the lack of clarity on what the financing mechanism for HSS support will be. This is particularly important because, at the core of HSS is the ability of a government to manage and spend its own domestic resources well.

Finally, the Global Health Framework calls for harnessing the UK science sector to improve global health. No doubt, it is important for the UK to think about its comparative advantage in global health. Indeed, the rapid development and production of the Oxford-AstraZeneca COVID-19 vaccine was one of the UK's biggest contributions to the pandemic. Oxford University claims it saved 6.3 million lives in the first year. (40) There is, however, a clear tied-aid agenda, and there may be times when it is better to look outside of the UK. For instance, why not invest in African vaccine research capacity? Putting the tied-aid agenda to one side, the UK should take a broader look at its

comparative advantage. It should go beyond science research and utilise its strengths in building health systems and identifying health system priorities, both in the NHS and in its academic centres. The delayed global COVID-19 vaccine roll-out is a reminder that great technology is not sufficient to deliver good health outcomes if the finances, health systems, institutions, and political will are not there to select cost-effective technologies and procure them for the populations who need them. As practical examples, this might mean partnering NICE with priority setting agencies around the world or partnering NHS England's healthcare workforce planning expertise with human resource departments in the ministries of health of LMICs.

Section 4: A five-point plan for the future of UK global health

Based on the challenges outlined in the paper, we propose a five-point plan that the UK can take to begin to restore its former strong global health reputation.

1. **Champion "more money for health" through debt relief and health taxes**
   Limited domestic resources are severely constraining LMIC's UHC objectives. Debt relief and health taxes should be championed by the UK as options to increase fiscal space. The World Bank estimates that debt relief could increase health expenditures by up to 9.7 percent in LMICs, depending on how its structured and used. (13) The UK was successful in advancing the Heavily Indebted Poor Countries Initiative from 1996–2005, and could partner with the African Union to make sure this rises up the G20's agenda in 2024. (41) Health taxes on tobacco, alcohol, and sugar are win-win interventions that can save lives, hold back the NCD epidemic, and raise around 0.6–0.7 percent of GDP, without holding back economic growth. (42) Other domestic resource mobilisation efforts will be challenging in the current context, but in the end this is a political choice in LMICs. The UK should therefore be ready to support specific policy windows and leaders when they emerge, seeking to take substantial strides towards UHC.
2. **Support countries to strengthen health system efficiency**
   Given the likely challenges in raising domestic resources for health, the UK could therefore provide technical assistance to support LMICs to achieve more impact with their limited budgets. One often overlooked option is to provide technical assistance on budget execution of existing allocated resources. Historical evidence suggests that support to better budget execution could increase health expenditure by 20–40 percent in sub-Saharan African countries. (43) The second option is to tackle inefficiencies in health expenditure. Indeed, estimates of inefficiencies in African health systems, for instance, suggest there is the potential to free up to 34 percent of current resource use for re-investment in priority services. (44) Specifically this could include funding support to integrated evidence-based priority setting systems that can improve the value for money of health expenditures.

These systems are highly effective at getting more value from domestic expenditure and can produce a return on investment of 9:1. (39) The UK can draw on the well-regarded expertise and reputation of the National Institute for Health and Care Excellence (NICE) to support countries through this process. It could also use its board positions to require global agencies such as Gavi and the Global Fund to further support, and align behind, national priority setting institutions.

3. **Don't try and do it all—track key priorities & focus on a few low-income countries**

   The UK must come to terms with being a smaller player in global health by improving the prioritisation (and de-prioritisation) of its global health financing. Firstly, it should set measurable, time-bound, prioritised objectives within the global health framework and monitor their progress and the allocation of financial flows to these objectives. This would give a clear steer to civil servants on the government's priorities and enable tracking of whether policies are translating into expenditure and practice.

   Secondly, the concentration of extreme poverty and the growth of populations within the poorest countries should strengthen the case to prioritise aid to these countries. For example, our colleague has previously proposed a target of 50 percent of UK aid to be spent on LICs. (47) By committing to being a long-term trusted partner in fewer countries the UK could also avoid the recent highly volatile swings in aid budgets. This would enable countries to plan the development of their health systems over a longer horizon.

   Thirdly, the UK could better prioritise by refreshing its internal approach to assessing value for money of global health projects. The UK might pilot approaches based on the principles of NICE in their approach to NHS priority setting. For instance, it could mean that the business cases for major projects establish two to three alternative courses of action consider the health and economic evidence base between them, go through appropriate peer review, deliberation, engagement of stakeholders and LMIC representatives, and finally publication of the minutes and justification of these decisions. This transparency would lead to better decisions but also increase public trust in the use of tax payers money, which may increase the probability of the UK returning to the 0.7 percent target. (48)

4. **Conduct a multilateral aid review that empowers LMIC decision-making**

   Following the FGHI process, the UK should carry out a broad review of multilateral funding for health, with the aim of expanding total funding, and aligning funding with desired reforms of the global health architecture. This means funding should be concentrated on the mechanisms that, in line with the white paper's commitment to localisation, put LMIC leaders in the driving seat, setting the priorities. It also means assessing how multilaterals manage tensions between global priorities such as climate change, AMR, and pandemic preparedness, with domestic LMIC priorities. For instance, inclusion of LMIC leaders in governance and decision-making, and whether the mechanism is able to ensure true additionality (i.e. non-ODA) of funds used for global challenges that substantially benefit

HICs. As France has done in its 2023 Global Health Strategy, this review should give serious consideration to regional mechanisms, which may be more effective and legitimate in handling trade-offs between national and regional/global objectives. (37) Finally, this review should be completed in 2024, sending a clear signal to partners and initiatives of the direction of travel of the UK, particularly given the Global Fund, Gavi and IDA replenishments are all due in 2025. (27)

5. **Direct financing of health systems though the World Bank and bilateral programmes**
   The UK should articulate a "Financing Health System Strengthening" position paper, describing how it will shift its overall health expenditure modalities to support HSS, both bilaterally and multilaterally. On the multilateral side, World Bank (e.g., IDA) funding is particularly well suited to supporting HSS. IDA concessional loans and grants are substantially directed by governments, allowing it to drive the priorities and invest in broad systems. (34) Given the breadth of the World Bank's remit, it is also better able than other mechanisms to support countries to consider trade-offs between NCDs and other priorities. Bilateral programmes are another strong candidate for financing HSS, if designed well, and the right countries are selected. In these contexts, the UK should aim for longer-term projects in fewer countries with increased coordination and pooling with other donors, including moving towards on-budget support where the situation allows. For this, the UK will need to accept losing some control and potentially increasing fiduciary risk. (45) As part of this, the UK should pilot a "new compact" on HSS financing, which involves an agreement where domestic financing focuses on the most cost-effective core services and donors shift aid resources to fund supplementary services. This is an empowering government-led and sustainable approach to financing HSS, which will enable a less disruptive transition from aid in the medium-term. (46)

Conclusion

The UK is at a crossroad in its contribution to global health. Whether it will take the steps needed to restore its reputation as a leader in global health will rest on the results of a possible 2024 general election.

Recent years have been plagued by cuts, including a 21 percent fall in UK expenditures from 2018–2022 (33 percent when you adjust for GNI growth), with a mismatch between where the cuts fell and stated UK priorities. Global health strategies and policies have lacked clarity about the top priorities, as well as a lack of measurable indicators to track if the policies were being financed or had impact. This occurred against a backdrop of what we identify as the three key trends that the UK must respond to—an acute-on-chronic health financing crises in LMICs; a concentration of poverty in fewer countries, the rise in NCDs, and the rise in global threats; and the inadequacy of the global health architecture.

To meet these internal and external challenges, the UK should launch a five-point plan in 2024: First, support countries through the current fiscal crises by championing debt relief and health taxes. Second, provide technical assistance to strengthen the efficiency of national health systems, with a focus on budget execution and priority setting. Thirdly, prioritise and deprioritise. Focus efforts on a few low-income countries and identify top priorities in the Global Health Framework and track progress and funding over time. Forth, carry out a review of multilateral funding with the aim of expanding total funding and intentionally consolidating funding on the mechanisms that support LMIC priorities. Fifth, direct funding for HSS through the World Bank and long-term bilateral programmes. Finally, it will need to take the time to earn back trust as a reliable and patient development partner.

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Annex A: Additional calculations on ODA expenditure

1. *Comparing nominal global health expenditure in 2022 with expected expenditure if it had been maintained at the 2018 percentage GNI:*
   - *In 2018 the UK spent 0.10 percent of GNI on global health*
   - *0.10 percent of 2022 GNI is £2.6 billion*
   - *True nominal 2022 spend on global health was £1.7 billion.*
   - *Making a difference of £844 million*

   Source: ONS, Statistics on International Development: Final UK Aid Spend 2022.

2. *Estimated UK global health spend through multilaterals in 2022:*
   The estimated UK health spend through multilaterals in 2022 was calculated by multiplying the UK's total 2022 contribution to each multilateral by the proportion of each multilateral that has been historically allocated to health over the past five years.

   With the exception of Gavi, the 2022 allocation to each multilateral was obtained from Table A8 of the UK *Statistics on International Development*. The allocation to Gavi had to be estimated separately, since the UK now funds Gavi via the International Finance Facility for Immunisation (IFFIm). Addendums to their business cases on Devtracker show that the UK's Gavi contribution was reduced by £300 million whilst its IFFIm contribution was raised by £461 million. We therefore assumed that 65 percent of contributions to IFFIm will make it to Gavi in 2022.

   The share of ODA gross disbursements allocated by each multilateral to health, averaged across the years from 2017–2021, was calculated from the OECD CRS.

TABLE A1. Allocation of UK overall multilateral aid to health

Multilateral	2022 Multilateral ODA Total £ Thousand	Proportion Allocated to Health (%)	Health Spend £ Thousands
Global Fund	£434,000	100%	£434,000
International Finance Facility for Immunisation	£227,047	62%	£140,769
World Health Organisation	£111,147	82%	£90,833
EU Institutions	£836,387	5%	£40,364
International Development Association	£315,610	11%	£33,332
African Development Fund	£299,769	1%	£4,340
UNAIDS	£8,000	45%	£3,562
UNFPA	£8,000	34%	£2,681
UNRWA	£13,000	15%	£2,004
Council of Europe Development Bank	£11,541	17%	£1,966
UNICEF	£8,000	16%	£1,265
Food and Agriculture Organisation	£15,163	7%	£1,014
WFP	£40,000	2%	£991
Global Environment Facility	£62,500	1%	£739
African Development Bank	£26,963	0%	£45
UN Peacebuilding Fund	£3,800	1%	£27
Caribbean Development Bank	£5,250	0%	£3
Global Alliance for Vaccines and Immunization	0	95%	0
Total			£757,935

Source: Authors own calculations based on ONS, Statistics on International Development: Final UK Aid Spend 2022.

Annex B: Additional tables breaking down bilateral ODA spend 2019–2022

TABLE B1. Bilateral health expenditure by broad sub-sector area (£m)

	2018	2019	2020	2021	2022	% Change from 2018–2022
Health (Total) - GBP thousands	1,319	1,426	1,589	967	976	–26%
Health, general	513	487	520	380	354	–31%
Basic health	436	488	737	375	396	–9%
Population Programmes & Reproductive Health	370	433	305	200	222	–40%
Non-communicable diseases (NCDs)	0	17	28	15	5	N/A

Source: ONS, Statistics on International Development: Final UK Aid Spend 2022.

TABLE B2. Bilateral health expenditure by managing department (£m)

	2018	2019	2020	2021	2022	% Change from 2018–2022
FCDO bilateral	1,056	1,103	1,220	652	720	–32%
Non-FCDO bilateral	267	328	369	318	255	–4%
Total	1,323	1,431	1,590	970	976	–26%

Annex C: Top 5 Sectors for UK bilateral ODA spend, 2018–2022

Rank	2018: Sector (% Bilateral Spend)	2019: Sector (% Bilateral Spend)	2020: Sector (% Bilateral Spend)	2021: Sector (% Bilateral Spend)	2022: Sector (% Bilateral Spend)
1	Multi-sector/ crosscutting (14.3%)	Humanitarian Aid (15%)	Health (16.7%)	Refugees in donor countries (14.7%)	Refugees in donor countries (38.9%)
2	Health (14.3%)	Health (13.9%)	Humanitarian Aid (16.1%)	Health (13.6%)	Humanitarian (11.6%)
3	Humanitarian Aid (14%)	Multi-sector/ cross-cutting (12.9%)	Multi-sector/ cross-cutting (11.7%)	Economic infrastructure & services (11.5%)	Health (10.3%)
4	Government and civil society (12.9%)	Government & civil society (12.8%)	Government & civil society (10.9%)	Multi-sector/ cross-cutting (11.1%)	Multisector/ cross-cutting (8.9%)
5	Economic infrastructure & services (12.2%)	Economic infrastructure & services (11.6%)	Economic infrastructure & services (9.8%)	Government & civil society (10.8%)	Government & civil society (7.6%)

Source: ONS, Statistics on International Development: Final UK Aid Spend 2022.