

Country Transition Projections up to 2040

GAVI, THE GLOBAL FUND, AND THE WORLD BANK'S IDA

 Adrian Gheorghe and Peter Baker

Abstract

Many countries are facing a much harsher budgetary prospect than a few years ago. For low and middle-income countries (LMICs) in particular, domestic health expenditure is expected to plateau or contract (in real terms) for many until 2027, development assistance for health has already plateaued, and a debt crisis is looming—all likely to squeeze budgetary space for health for many years ahead. This paper updates a previous Center for Global Development mapping of potential transitions for health aid in light of up-to-date 2023 economic projections and transition policies of three mechanisms with explicit eligibility rules: Gavi, The Vaccine Alliance (Gavi); the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM); and the World Bank's International Development Association (IDA). By “transition,” we refer to the year when a country is expected to no longer meet eligibility rules for one of the three mechanisms and for the related health aid to stop (gradually, as applicable). We find that, of 104 LMICs included in our analysis, 44 countries will be above the eligibility threshold of at least one mechanism by 2040. This is higher than expected based on projections informed by April 2017 economic prospects (26 countries), which suggests that events during the past three years have not derailed transition prospects. However, eligibility and transition policies need to respond to the reality that these countries' budgetary space may be more constrained (e.g., by debt repayments) than in previous transition phases. There are important differences between the three mechanisms due to differences in their eligibility policies, with fewer transitions in Gavi's and GFATM's portfolios than in IDA's. In addition, 60 countries are not projected to cross any eligibility threshold by 2040. This implies a commitment to supporting these countries well beyond the Sustainable Development Goals era, which may not be the policy intent of their donors. We argue that these findings call for a coordinated reexamination of the principles and content of eligibility and transition policies of the major global health financing mechanisms.

Country Transition Projections up to 2040: Gavi, the Global Fund, and the World Bank's IDA

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Abbreviations

CGD	Center for Global Development
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GDP	gross domestic product
GNI	gross national income
IDA	World Bank's International Development Association
IMF	International Monetary Fund
LMIC	low- and middle-income countries
WEO	World Economic Outlook
WHO	World Health Organization

1. Introduction

In the aftermath of COVID-19, economic growth constraints brought about by the war in Ukraine, and spiralling debt, many countries now face a much harsher budgetary prospect than a few years ago. In most low- and middle-income countries (LMICs), real domestic health expenditure is expected to plateau or contract until 2027 (1). Health expenditure challenges are further compounded by already plateauing levels of development assistance for health and rising debt repayments (2), and increased demand due to backsliding on the burden of other health conditions during COVID-19. Many of these factors are concentrated in lower-middle-income countries (i.e., countries that have initiated or just completed their graduation from aid), and thus overall, they may be expected to produce a step change in aid transition dynamics for the Sustainable Development Goals era and beyond.

A Center for Global Development (CGD) working paper published in July 2018 mapped an indicative timeline of transition from development assistance for health through 2040 across five global health financing mechanisms¹ (hereafter “mechanisms”) based on International Monetary Fund (IMF) World Economic Outlook (WEO) data released in August 2017 and the mechanisms’ transition policies at the time (3). The paper found that by 2040, both Gavi, The Vaccine Alliance (Gavi) and the World Bank’s International Development Association (IDA) would see major transformations of their funding portfolios, while few large or aid-dependent countries would transition from Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM or Global Fund) support; and within a very narrow time frame, a handful of countries would face many major transitions whose cumulative budgetary effect may be substantial, even if each individual transition should be manageable.

This paper updates the transition mapping in light of up-to-date economic projections and transition policies of three mechanisms with explicit eligibility rules: Gavi, GFATM, and IDA. In 2019, Institute for Health Metrics and Evaluation estimates US\$46 billion was provided in development assistance for health, and approximately US\$7.4 billion were disbursed through these three mechanisms: US\$3.4 billion through GFATM, US\$2.3 billion through Gavi and US\$1.7 billion through IDA (4). Our objectives were to

- describe potential trends in transitioning countries up to 2040 and the implications for the portfolios and policies of the financing mechanisms; and
- identify transitioning countries that are highly reliant on these mechanisms and/or may undergo multiple transitions simultaneously.

We acknowledge that for every country, transitioning from aid is a complex, multiyear, and rarely linear process with potentially far reaching political and budgetary implications. Throughout this paper, “transition” refers to the future year when, based on reasonable projections, a country is

1 These include Gavi, The Vaccine Alliance; the Global Fund to Fight AIDS, Tuberculosis, and Malaria; the World Bank’s International Development Association; the Global Polio Eradication Initiative; and the US President’s Emergency Plan for AIDS Relief.

expected to no longer meet current eligibility rules for one of the three mechanisms (Gavi, GFATM, and IDA) and to start the transition process. We offer no judgement on when disbursements from the three mechanisms are expected to end once the transition process starts.

In our analysis of 104 LMICs that received disbursements from at least one of the three mechanisms in 2019 and 2020, 44 countries will be above the eligibility threshold of at least one mechanism by 2040. This is more than expected based on projections informed by April 2017 economic prospects (26 countries), which suggests that events during the past three years have not derailed transition prospects. However, there are important differences between the three mechanisms: Gavi's and GFATM's portfolios are likely to change less than IDA's, while IDA is likely to see important transformations and several transitioning countries facing high exposure to IDA warranting particular attention. On the other hand, 60 countries are not projected to cross any eligibility threshold by 2040. We argue that these findings call for a coordinated reexamination of eligibility and transition policies of the major global health financing institutions.

The paper is structured as follows: Section 2 outlines the methods; Section 3 presents transition prospects for countries currently eligible for Gavi, GFATM, and IDA, respectively; Section 4 discusses policy implications; and Section 5 provides concluding remarks and recommendations.

2. Methods

This section gives a brief overview of our methods, with more details provided in appendices.

We focused on 104 LMICs that received disbursements from at least one of Gavi, GFATM, or IDA in both 2019 and 2020. This choice of years excludes countries that started receiving support in 2020 during the COVID-19 response and countries that graduated from financing support in 2019. We also excluded Afghanistan, Democratic People's Republic of Korea, Kosovo, and Syria from the analysis, since they received disbursements in 2019 but do not have official GDP projections after 2022. We also excluded Ukraine given the uncertainty over its economic situation at the time of writing this paper. The list of included countries is in Appendix 1.

The eligibility and transition policies of all three mechanisms rely in some way on GNI per capita, measured in current US dollars using the Atlas method (Table 1). IDA and GFATM also consider creditworthiness and disease burden, respectively. All mechanisms implement gradual, multiyear, and flexible transition policies once eligibility criteria are no longer met.

We constructed country-year projections of GNI per capita up to the year 2040, based on GDP data (see Appendix 1 for details), and compared these projections with the eligibility criteria of each mechanism to approximate when each country would no longer be eligible. In doing so, we assumed that the substance of the eligibility rules would not change until 2040. Two parallel sets of projections were constructed to compare transition prospects before and after COVID-19:

- One set starting from data in the IMF WEO April 2017 release (5), which has official IMF projections up to 2022 inclusive for most countries. In essence, we replicated CGD’s earlier analysis that used 2017 data but with one modification: We assumed each mechanism’s eligibility threshold changes over time and projected threshold values into the future.
- Another set starting from GDP data in the IMF WEO April 2023 release (6), which has official IMF projections up to 2028 inclusive for most countries.

TABLE 1. Eligibility and transition policies for Gavi, the Global Fund, and IDA

Mechanism	Year of Last Policy Revision	Summary of Relevant Policies
Gavi	An updated Eligibility and Transition Policy, version 3.0, has been in effect since June 2018. ^a There is also a Co-financing policy, last updated in 2016. ^b	<p>As of 2023, countries are eligible if their three-year average of GNI per capita is equal or below US\$1,730.^c</p> <p>The threshold value is updated yearly with inflation. We explored a 4% and a 2% growth rate.</p>
GFATM	The Eligibility policy was last revised in 2022. ^d	<p>The latest three-year average of GNI per capita (Atlas Method) is compared against the World Bank income group thresholds for the year that determinations are made. Low-income and lower-middle-income countries are eligible regardless of disease burden. Upper-middle-income countries are eligible if:</p> <ul style="list-style-type: none"> • The country has a high disease burden: <ul style="list-style-type: none"> ◦ HIV/AIDS: HIV national prevalence $\geq 1\%$ OR prevalence in a key population $\geq 5\%$, based on data from UNAIDS and WHO. ◦ Tuberculosis: TB incidence rate per 100,000 ≥ 50 OR proportion of new TB cases that are drug-resistant (resistance to rifampicin) $\geq 5\%$, based on data from WHO. ◦ Malaria: Death rate from malaria is 12 or more per 100,000 persons at risk of the disease OR the country contributes 0.25% or more to global malaria deaths OR the death rate is less than 12 per 100,000 at risk of malaria but more than 65 per 1,000 people at risk have the disease OR the country has a documented artemisinin resistance or partner drug resistance, based on data from WHO. <p>AND</p> <ul style="list-style-type: none"> • For HIV/AIDS, the country is on the Organisation for Economic Co-operation and Development’s Development Assistance Committee List of Official Development Assistance recipients.

TABLE 1. (Continued)

Mechanism	Year of Last Policy Revision	Summary of Relevant Policies
IDA	The eligibility policy and graduation process were last reviewed in 2018. ^e	As of 2023, countries are eligible if their GNI per capita is below the IDA operational cut-off of US\$1,255 and they lack creditworthiness to borrow on market terms and therefore have a need for concessional resources to finance the country's development program. ^f In addition, countries are then assessed to determine how well they implement policies that promote economic growth and poverty reduction. There have been special provisions for small island economies since 1985.

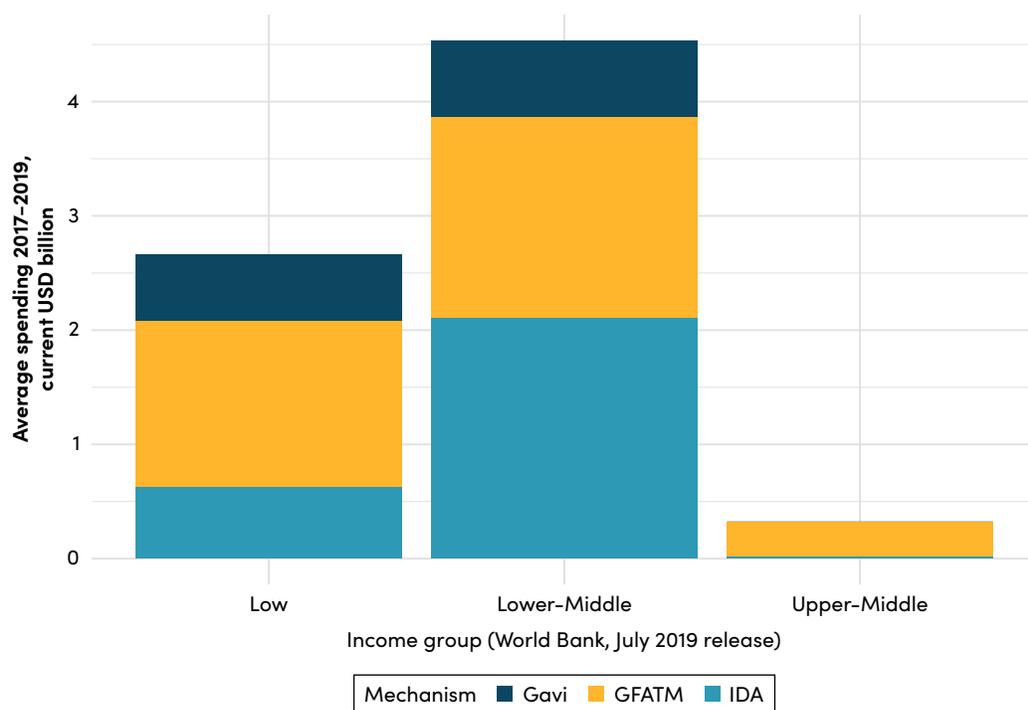
Notes: a) Gavi, "Eligibility and Transition Policy, Version 3.0," June 2018, <https://www.gavi.org/sites/default/files/document/gavi-eligibility-and-transition-policy.pdf>. b) Gavi, "Co-financing Policy, Version 2.0," June 2016, <https://www.gavi.org/sites/default/files/document/gavi-co-financing-policy.pdf>. c) "Eligibility," Gavi, last updated March 17, 2023, <https://www.gavi.org/types-support/sustainability/eligibility>. d) Global Fund, "Revisions to the Eligibility Policy," May 2022, https://www.theglobalfund.org/media/12050/bm47_02-revised-eligibility-policy_report_en.pdf. e) IDA, "Transitioning out of IDA Financing: A Review of Graduation Policy and Transition Process," October 2018, <https://documents1.worldbank.org/curated/en/648731542748974532/pdf/ida18-mtr-graduation-policy-review-10312018-636767929247403732.pdf>. f) "How Does IDA Work?," IDA, last updated August 10, 2023, <https://ida.worldbank.org/en/about/how-does-ida-work>.

3. Transition projections

3.1. Overview

Of the 104 countries included in the analysis, 26 were low income, 46 were lower-middle income and 32 were upper-middle income (13). Nearly half of these (48 countries or 45 percent) received disbursements from only one of the three mechanisms and more than one-third (40 countries or 37 percent) received disbursements from all three mechanisms (see Appendix 2 for a detailed breakdown). Funding for all three mechanisms was directed predominantly toward lower-middle- and low-income countries (Figure 1).

FIGURE 1. Disbursements by mechanism and income group for the 104 countries analysed



By 2040, 22 countries that are currently below at least one mechanism’s GNI-based threshold will cross it by 2040, which is 17 more than expected based on 2017 GDP projections data (Table 2). When recipient countries that are already above the threshold are also considered, 44 countries will be above at least one mechanism’s threshold by 2040—some of which expected to transition by then.

Additional details by mechanism are in Appendix 2. Gavi and IDA are projected to see recipient countries meeting the GNI-based criteria currently accounting for about 19 percent and 40 percent of their portfolios, respectively; for Gavi, these are primarily countries already above the threshold—only one country representing 1 percent of disbursements is newly set to transition (Cambodia). Ten countries supported by the Global Fund are projected to become high income and lose eligibility, but they currently account for small amounts (1 percent).

TABLE 2. Number of countries projected to be above the GNI-based eligibility criteria by 2040

Economic Data Source	Evolution Against the Eligibility Threshold	Number of Countries
WEO April 2017	Backslide: above threshold in 2023, below threshold in 2040	6
	Transition: below threshold in 2023, above threshold in 2040	5
	Stay above: above threshold in 2023 and staying above in 2040	21
	Stay below: below threshold in 2023 and staying below in 2040	96
WEO April 2023	Backslide: above threshold in 2023, below threshold in 2040	5
	Transition: below threshold in 2023, above threshold in 2040	22
	Stay above: above threshold in 2023 and staying above in 2040	23
	Stay below: below threshold in 2023 and staying below in 2040	88

Note: Figures in this column denote the number of distinct countries that backslide/transition/stay above/stay below the eligibility threshold in at least one of the three mechanisms. The column total is higher than the total number of countries analysed ($n = 104$) because some countries are expected to transition from one but not all the mechanisms they receive.

Six countries are expected to face double transitions, all of them from Gavi and IDA; five of these have already crossed at least one threshold (Bangladesh, Djibouti, Cote d'Ivoire, Papua New Guinea, and Nigeria) and one is projected to cross both before 2040 (Cambodia, where Gavi and IDA combined account for about 2.6 percent of current health expenditure).

3.2. Gavi

Eligibility for Gavi support is based on whether a country's three-year average GNI per capita is below a threshold updated every year to account for inflation. Given the difficulty of predicting long-term inflation, we project two growth scenarios—one with 4 percent annual growth and one with 2 percent annual growth, their justifications being outlined in Appendix 1.

In summary, the projections suggest that nine countries may transition by 2040 representing about 19 percent of Gavi disbursements, of which only one country is a new transition (Cambodia); two countries (Ghana and Kenya) may backslide into eligibility. The countries with the highest exposure to Gavi financing are unlikely to enter accelerated transition. Moreover, the majority of Gavi recipient countries, currently representing about 80 percent of Gavi disbursements, are likely to remain eligible for Gavi support by 2040, and indeed *diverge away* from the transition threshold. Indeed, Gavi has acknowledged it is likely to cover a substantial amount of African demand for the foreseeable future (7).

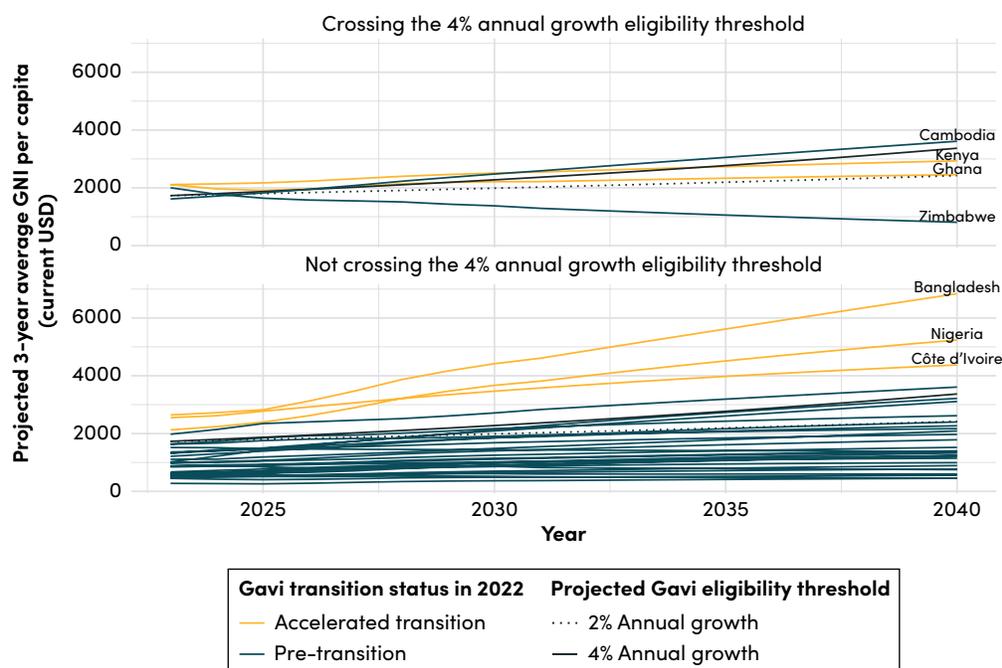
If Gavi's eligibility threshold increases by 4 percent each year, which is in line with the latest update of the threshold for 2022–2023, nine countries (representing 18 percent of Gavi's current

disbursements) are projected to be above the threshold by 2040. Seven of these nine countries are already in accelerated transition and would have most likely graduated fully from Gavi support before 2040; the other two countries are currently in pre-transition (Cambodia and Haiti).

If Gavi’s eligibility threshold were to increase at a slower pace of 2 percent annually (which is the average growth rate of its threshold between 2018 and 2023), 19 countries (representing 28 percent of Gavi’s current disbursements) are projected to be above the threshold by 2040, of which 6 countries are currently in pre-transition and 9 are currently in accelerated transition.²

Among the 20 countries currently receiving the highest disbursements from Gavi, which account for 80 percent of all Gavi disbursements, 15 countries are in pre-transition, and their prospects are not projected to change (Figure 2). Five of these top recipients are in accelerated transition,³ but remarkably, two may backslide and become eligible again after 2030: Ghana is projected to become eligible for Gavi support again after 2030 irrespective of how Gavi’s eligibility threshold evolves, while Kenya may become eligible again after 2035 if Gavi’s eligibility threshold grows at 4 percent annually.

FIGURE 2. Projected three-year average GNI per capita for Gavi top recipient countries, 2023–2040



Notes: The upper panel shows countries that are projected to cross the eligibility threshold by 2040, either upwards (i.e., lose eligibility) or downwards (i.e., return to eligibility). The lower panel shows countries that are not projected to cross the eligibility threshold by 2040 (i.e., complete transition already started or remain eligible). In the lower panel, the country currently in pre-transition but above the eligibility threshold is Haiti.

2 Kenya and Solomon Islands are the two countries currently in accelerated transition, which in 2040 would be above the Gavi threshold if it grows at 2 percent annually and below it if it grows at 4 percent annually.
 3 There are 10 Gavi recipient countries currently in accelerated transition; only 5 of these, discussed in this section, are among top Gavi recipients.

The majority of Gavi recipient countries that were expected to transition based on pre-COVID-19 economic data are still likely to transition. The notable exceptions are Lao, Myanmar, and Sudan, which had much better prospects pre-COVID-19 than they currently do and are now unlikely to reach Gavi's eligibility threshold before 2040 (Appendix 2). On the other hand, Cote d'Ivoire and Nigeria were not expected to reach the threshold in 2040 based on 2017 data but now are likely to. The potential backsliding of Kenya and Ghana is aligned with 2017-based projections.

In half of Gavi's recipient countries, its disbursements represent more than 2 percent of current health expenditure, and these countries can be considered highly exposed to Gavi financing. None of these highly exposed countries are expected to enter accelerated transition by 2040.

3.3. The Global Fund

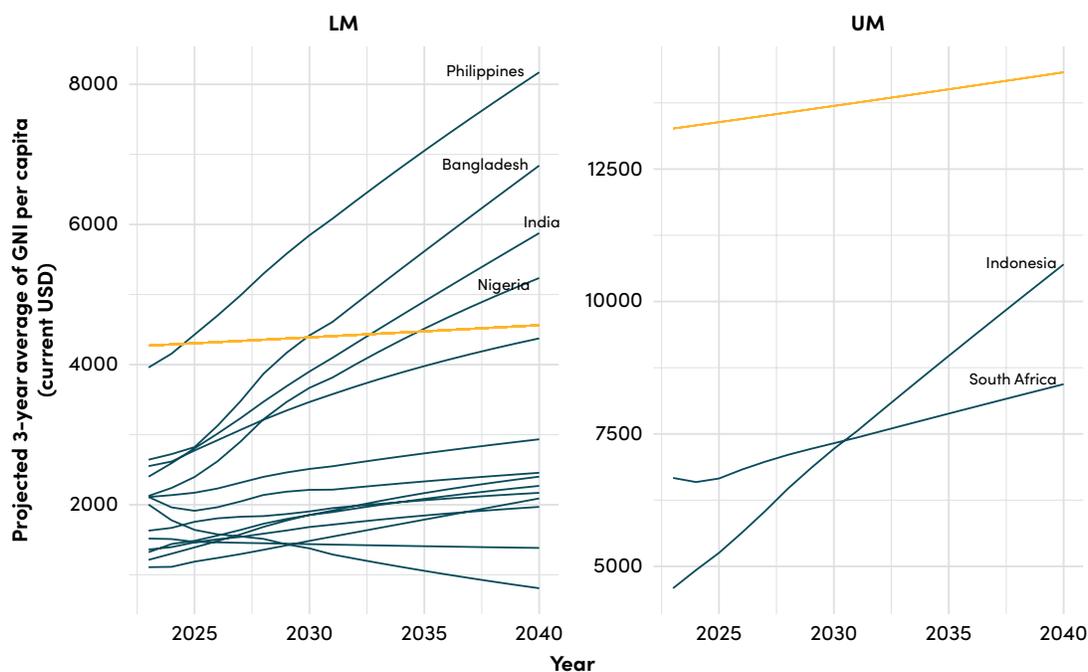
All countries whose three-year average GNI per capita is below the World Bank's lower-middle-income and upper-middle-income thresholds are eligible for GFATM support, while those below the high-income threshold are eligible if they meet one of the disease burden criteria.

In summary, GFATM's portfolio will see more changes than previously expected, with 10 countries (rather than 2) projected to transition due to becoming high income. However, these countries represent only 1 percent of GFATM's portfolio by disbursements.

Of 29 upper-middle-income countries currently receiving GFATM financing, 10 countries are projected to become high income by 2040 and thereby lose eligibility for GFATM support. These countries currently account for about 1 percent of GFATM disbursements. In projections based on pre-COVID-19 data, only 2 countries (accounting for less than 0.5 percent of GFATM disbursements) would attain high-income status by 2040.

When examining projections for the top GFATM recipient countries, accounting for 80 percent of current disbursements, four countries (Bangladesh, India, Nigeria and Philippines, accounting together for about 12 percent of current GFATM disbursements) are expected to cross the upper-middle-income threshold (Figure 3). This transition would trigger the consideration of disease burden indicators, per GFATM's eligibility policy. An examination of the latest data for these countries (see Appendix 2) suggests that all countries would remain eligible for at least one disease component (malaria, TB, or HIV).

FIGURE 3. Projected GNI per capita of GFATM lower-middle- and upper-middle-income countries among top 20 recipients, 2023–2040



Notes: Income groups based on World Bank, July 2019 release. Gold lines denote projected income group thresholds based on past observed growth.

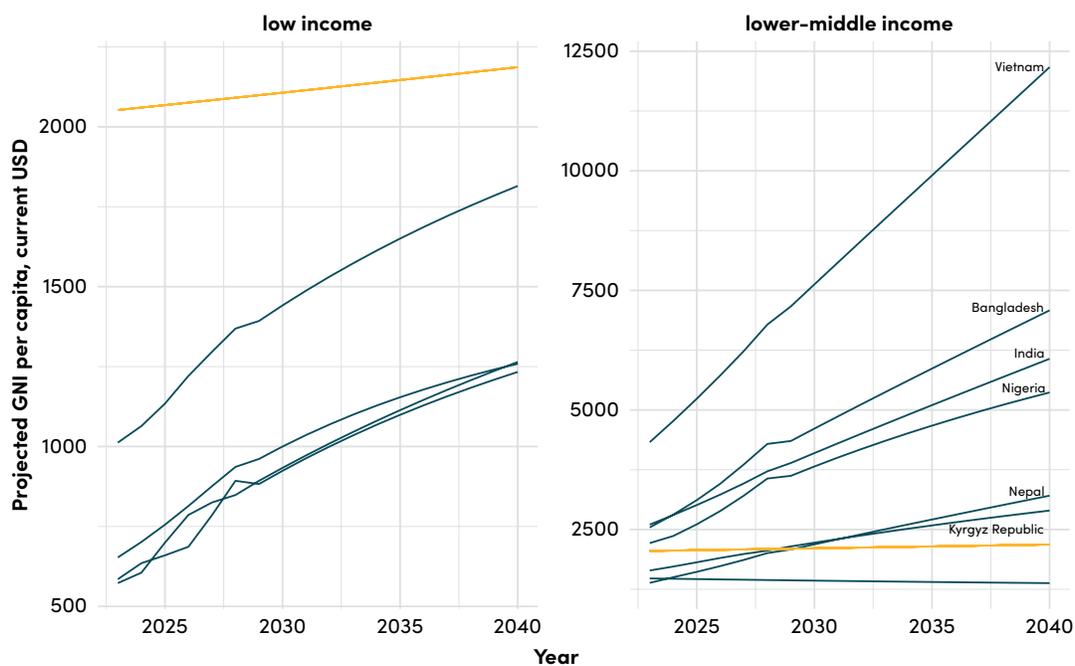
Of the lower-middle-income GFATM recipient countries where GFATM disbursements represent more than 2 percent of current health expenditure, two countries are expected to attain upper-middle-income status: Djibouti and Eswatini; all are likely to remain eligible based on the disease burden criteria.

3.4. IDA

Eleven countries (four low income and seven lower-middle income) make up 80 percent of the IDA country-specific health sector disbursements.⁴ Four lower-middle-income countries are already above the eligibility threshold and three are not, of which Nepal and Kyrgyz Republic are projected to cross the eligibility threshold around or after 2030 (Figure 4). This is significant because Nepal and Kyrgyz Republic are the first- and third-highest of IDA's health-focused disbursements, respectively, currently accounting together for 18 percent of the entire IDA health-focused portfolio and 29 percent of its country-focused health portfolio. The four low-income countries are likely to remain eligible.

4 Given how IDA disbursements were calculated based on the available data (see Appendix 1), the percentages reported in this section are rather indicative and need to be viewed with more caution than those for Gavi and GFATM in the previous sections. Regional projects, which are not specific to a single country, represent about 35 percent of IDA health-focused commitments.

FIGURE 4. Projected GNI per capita of IDA top 20 recipient countries for health sector projects, 2023–2040



Notes: Income groups based on World Bank, July 2019 release. Gold lines denote projected IDA eligibility threshold based on past observed growth.

Among the countries where IDA disbursements currently exceed 2 percent of current health expenditure, three countries are projected to cross the IDA eligibility threshold by 2040: Nepal, Haiti, and Kyrgyz Republic (see Appendix 2). Nepal and Kyrgyz Republic are particularly notable, again, as IDA health support currently represents about 40 percent and 55 percent of current health expenditure, respectively.

4. Policy implications

4.1. Overall transition prospects are surprisingly unchanged, but this hides countries' underlying reduced budgetary space

Overall, our analysis found that the global shocks of the past few years do not appear to have slowed down LMICs' growth enough to markedly change their future eligibility for the three mechanisms. In fact, in the aggregate, more countries (44) than previously expected (26) are projected to be above the eligibility threshold of at least one mechanism by 2040; most likely, this is the result of better-than-expected economic performance just before COVID-19 and of the COVID-19 rebound. At the other end of the income scale, 60 of the 104 countries analysed are currently not meeting the eligibility criteria of any of the three mechanisms and are not projected to meet any of them by 2040.

This lack of change brings to light the overreliance on GNI as an indicator of domestic budgetary space. With a debt crises and challenging economic context, it may be argued that countries with the same GNI today do not have the budgetary space they had prior to COVID (2). This has been acknowledged by the Gavi board, who decided in December 2022 to extend the transition period from five to eight years (8). While this may make sense as a short-term solution for the selection of countries involved, our projections suggest that three more years are unlikely to make a difference in terms of most countries' economic performance. Eligibility policies may therefore need more subtle assessments of budgetary space in the future.

There also appears to be more divergence in GNI projections within income groups, most likely the result of countries finding themselves in different economic positions after COVID-19. The prospects of countries sliding back into eligibility after having crossed the thresholds remains palpable, and more countries (eight) are expected to see such a trend than previously expected (six). The implication is that the limitations of articulating eligibility policies in terms of universally applied hard thresholds and broad income groups will become more and more obvious.

4.2. Each financing mechanism uses a different eligibility threshold, which really matters for focusing resources on the greatest needs

From the perspective of the financing mechanisms, the most notable projected change relates to the lower-middle-income countries projected to cross the Gavi and IDA eligibility thresholds by 2040, representing about 19 percent and 40 percent of current disbursements, respectively. The difference is partly due to Gavi having a significantly higher threshold for eligibility. GFATM, with an even higher threshold, will see less than 2 percent of its disbursements transition.

All things being equal, this prospect may trigger changes in these mechanisms' portfolios, for example, by releasing funds that could be directed toward fewer countries and tilting further toward supporting low-income countries. Therefore, setting the threshold is a powerful way to support prioritisation of resources. Indeed, all three mechanisms examined in this paper, as well as all other health donors, are looking at a future where they will find it increasingly difficult to balance need (populations), response (health technologies), and resources (funding). Global health funding was already plateauing before COVID-19. New health technologies such as the malaria vaccine are coming to market. Preparing for the next pandemic and climate change will also be costly. Boards will therefore need to carefully consider eligibility criteria in the light of stagnant resources and competing needs.

4.3. There is a core group of low-income countries with rising populations and no sign of transition

Of the countries in our analysis, 60 are not projected to cross the GNI-based eligibility threshold of any of the three mechanisms by 2040, and for Gavi, most of these are *diverging away* from

the threshold for transition. Indeed, recipient countries accounting for more than 95 percent of GFATMs portfolio and 60 percent of Gavi’s portfolio are likely to remain eligible until 2040 and beyond. Their boards will need to consider if this long-term commitment to these countries with no additional transitions is their intention.

These countries’ demographics are changing fast. By 2040, together they will host 570 million more people than today, a 32 percent increase from 1.8 billion (2022) to 2.37 billion (2040). They will also represent a higher share of the total world population and will have a cumulated 5.3 million more births each year than they do today, a 12 percent increase from 44.8 million (2022) to 50.7 million (2040). As such, even if the countries currently above the eligibility thresholds transition completely by 2040, population needs of the remaining, non-transitioning countries are also going to grow substantially during that period.

If the country-specific per capita spending of each mechanism remains the same as it is today, accounting for population growth in these 60 countries means that by 2040, the financing needs will be lower than today, but not markedly so, particularly for Gavi and GFATM (Table 3).

TABLE 3. Projected spending by mechanism in 2040 in 60 low- and lower-middle-income countries

Mechanism	Average Spending Over 2017–2019 in the 104 Countries Included in the Analysis (US\$ Billion, Current Values)	Projected Spending in 2040 in the 60 Countries not Expected to Begin any Transition, Assuming Present per Capita Spending by Country and Mechanism (US\$ Billion, Current Values)
Gavi	1.25	1.03
GFATM	3.52	2.91
IDA	2.74	1.48

4.4. Some transitions are worse than others and will need a customised exit plan

Some LMICs are particularly reliant on specific health financing mechanisms and therefore are highly exposed to the prospect of transitioning from support, given the share of the respective mechanism in current health expenditure. Avoiding sharp funding disruptions in these countries will require careful monitoring, additional domestic resource mobilisation, and coordination of development partners.

Limitations

Like any projection work, there are inherent limitations in the approach, methods, and data sources. Projections are not predictions but can be useful in understanding the broad landscape and in articulating coherent responses. All shares of disbursements by mechanism are indicative, and it

must be reiterated that the analysis of IDA's health portfolio is less reliable than for Gavi and GFATM given how publicly available data is structured and presented.

5. Conclusions and recommendations

Based on this review, we conclude that bolder, more transformative thinking around eligibility policies is warranted to meet the needs of the post-COVID era. Our work shows that the current policies will result in most countries remaining eligible for support for an indefinite period. This implies an assumption that replenishments will continue to be successful and is also not in line with an objective of gradually reducing aid dependency. These policies also risk the funds spreading themselves too thin on too many countries and being unable to focus on countries that are a particular priority. This challenge is likely to get worse if donor funding reduces and more technologies become available that need funding, such as malaria and TB vaccines. Current policies are also overly focused on a single metric—GNI, which makes them unresponsive to countries' budgetary reality, resulting in mismatches between budgetary space for health and GNI.

We encourage the financing mechanisms to convene their boards and begin a coordinated, strategic review of their current eligibility policies, building on already ongoing processes of rethinking the internal governance of major development actors such as the World Bank Group (9) and recent, high-level calls to reform the international development architecture (10).

We propose that the vision should be devising prioritisation, allocation, and eligibility policies that would account for fluctuations (particularly potential decreases) in donor resources over time (e.g., by linking thresholds for country transition to level of replenishments and by ordering recipient countries in terms of priority to access available resources); and would treat recipients of health aid not as a group (e.g., based on income levels) but using a more tailored approach based on clear principles and relevant data.

A first step can be for each financing mechanism board to reexamine and confirm the core principles and criteria for eligibility, which dictate who gets what for how long. Is it primarily around equity and poverty reduction, whichever country someone lives in? Or around support for countries that cannot provide essential services using domestic resources? Or is it about efficiency and maximum impact on disease burden? Is time-bounded aid a pragmatic preference or a deeper value? This critical dialogue would likely also inform a clearer, more meaningful definition of what “transitioning from aid” means.

For example, if the focus is on equity and poverty reduction, it can be argued that low-income countries, particularly those with the highest disease burden, should get a larger share of the portfolio than they do now. Making time boundedness of external financing support a core value rather than a preference would entail devising eligibility policies based on other indicators that are

faster moving than GNI. More than half of the 104 analysed countries for the three mechanisms are projected to stay eligible two decades from now; as such, under the current eligibility policies, aid is only notionally time bounded. Bringing into focus ability to pay, reflected by co-financing levels, requires access to timely and detailed country health accounts data or at least public finance information. Finally, a decision to focus on value for money would entail allocating finances toward technologies and interventions that are demonstrably high value, even if they happen to be most needed in middle income countries, and not in the poorest countries.

The final step would be to align these principles across donors' eligibility policies and criteria so that countries can develop coherent policy responses. In another paper, we outline such an approach, where donors and countries come together to develop a new health financing compact and set evidence-based priorities (11). Then, domestic resources can be used for the highest-priority services, with funders supplementing this at the margin. Such options would enable a much more coherent and planned transition from aid as countries develop.

Appendix 1. Methodological details

List of the 104 countries included in the study: Albania, Algeria, Angola, Armenia, Azerbaijan, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia, Botswana, Burkina Faso, Burundi, Cote d'Ivoire, Cabo Verde, Cambodia, Cameroon, Central African Republic, Chad, Colombia, Comoros, Democratic Republic of the Congo, Congo, Costa Rica, Cuba, Djibouti, Dominican Republic, Ecuador, Egypt, El Salvador, Eritrea, Eswatini, Ethiopia, Gabon, The Gambia, Georgia, Ghana, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iran, Jamaica, Kazakhstan, Kenya, Kyrgyz Republic, Lao PDR, Lesotho, Liberia, Madagascar, Malawi, Malaysia, Mali, Mauritania, Moldova, Mongolia, Montenegro, Morocco, Mozambique, Myanmar, Namibia, Nepal, Nicaragua, Niger, Nigeria, Pakistan, Papua New Guinea, Paraguay, Peru, Philippines, Rwanda, Sao Tome and Principe, Samoa, Senegal, Serbia, Sierra Leone, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, St. Lucia, Sudan, Suriname, Tajikistan, Tanzania, Thailand, Timor-Leste, Togo, Tunisia, Turkmenistan, Tuvalu, Uganda, Uzbekistan, Vanuatu, Vietnam, Yemen, Zambia, Zimbabwe.

To construct country projections of GNI per capita, we made the following assumptions and approximations:

- Since projections of GNI are not available, but medium-term projections of the GDP by the IMF are available up to 2027 inclusive at the time of writing, projected GNI was calculated (following the approach recently taken by GFATM (12)) as projected GDP multiplied by an elasticity factor. The elasticity factor was calculated for each country as the ratio of differences between GNI and GDP over the past eight available years from the World Bank World Development Indicators database (13)—for most countries, these were 2021 and 2013. Projected GNI per capita was obtained by dividing the projected GNI by the projected midyear population (medium variant) from the United Nations World Population Prospects 2022 Database (14).
- For countries where GDP was projected to decline to unrealistic values, manual adjustments were made to keep positive, realistic values.
- All three World Bank income thresholds (low- to lower-middle-income, lower-middle- to upper-middle-income, and upper-middle- to high-income) were assumed to increase by 6 percent every year over the projection interval, in line with the average historical change observed between 2015 and 2020.

Projection methods. The last available year for which GDP projections are available is 2028 for most countries (April 2023 release). Projected GDP beyond official projections for 2029–2040 was calculated using a country-specific linear regression of GDP over calendar year for the interval 2021–2028, with the resulting regression equation further used for out-of-sample prediction with calendar year as independent variable. Projections based on IMF WEO April 2017 data were constructed similarly based on the last seven years of available data, which for most countries was the interval 2016–2022.

How well does this linear projection method work? We used historical GDP data in the IMF WEO October 2022 release to examine the extent to which pre-2005 GDP data predicts GDP data observed in 2022 for LMIC. The Spearman correlation coefficients between country GDP predicted for 2022 based on 1999–2005 GDP data and the observed GDP in 2022 were 0.991 for low-income countries, 0.976 for lower-middle-income countries and 0.927 for upper-middle-income countries.⁵ As such, the linear projection approach appears to predict GDP well in the long run for low- and lower-middle income countries, and slightly less so but still well enough for upper-middle income countries.

To approximate the amounts disbursed to recipient countries from each mechanism, we used d-portal data from the International Aid Transparency Initiative (15) for Gavi and GFATM, years 2017–2019. For IDA, we used the [World Bank project list](#) (16) filtered by Financing Type “IDA” and Sectors “Health” and “Public administration–health,” which lists project commitments, not net disbursements. This is an approximation as we could not identify country-year-sector (health) disaggregated data for IDA disbursements. After retaining only projects approved between 2010 and 2019 ending after 2017, we divided the “total IDA and IBRD commitment” for each project by the difference between the project start year (assumed to be the year when the project was approved by the board) and the project end year (from the project closing date) to approximate IDA commitments by country and year. We retained only commitments for the years 2017–2019.

To compute the share of disbursements for each country, by mechanism, we divided the amounts above by the current health expenditure in each country from the World Health Organization (WHO) Global Health Expenditure Database (17) and took the average for 2017–2019.

To approximate the future value of thresholds/cut-offs, expressed in current US\$, we relied on historical data. For the IDA operational cut-off, the average year-on-year percentage increase over the years 2013–2020 was used. For Gavi, we use two values for the annual growth rate used in projecting its threshold: 4 percent, which is the last percentage increase from 2022 (US\$1,660) to 2023 (US\$1,730); and 2 percent, which is the compound annual growth rate observed over five years, between 2018 (US\$1,580) and 2023 (US\$1,730) (the exact value is 1.83 percent, rounded up to 2 percent). For the Global Fund, which used the World Bank income group thresholds, the average year-on-year percentage increases of these thresholds over the years 2013–2020 were used.

5 Income groups as of 2005 in this context.

Appendix 2. Additional data

TABLE 4. Number of countries projected to be above the GNI-based eligibility criteria by 2040, by mechanism

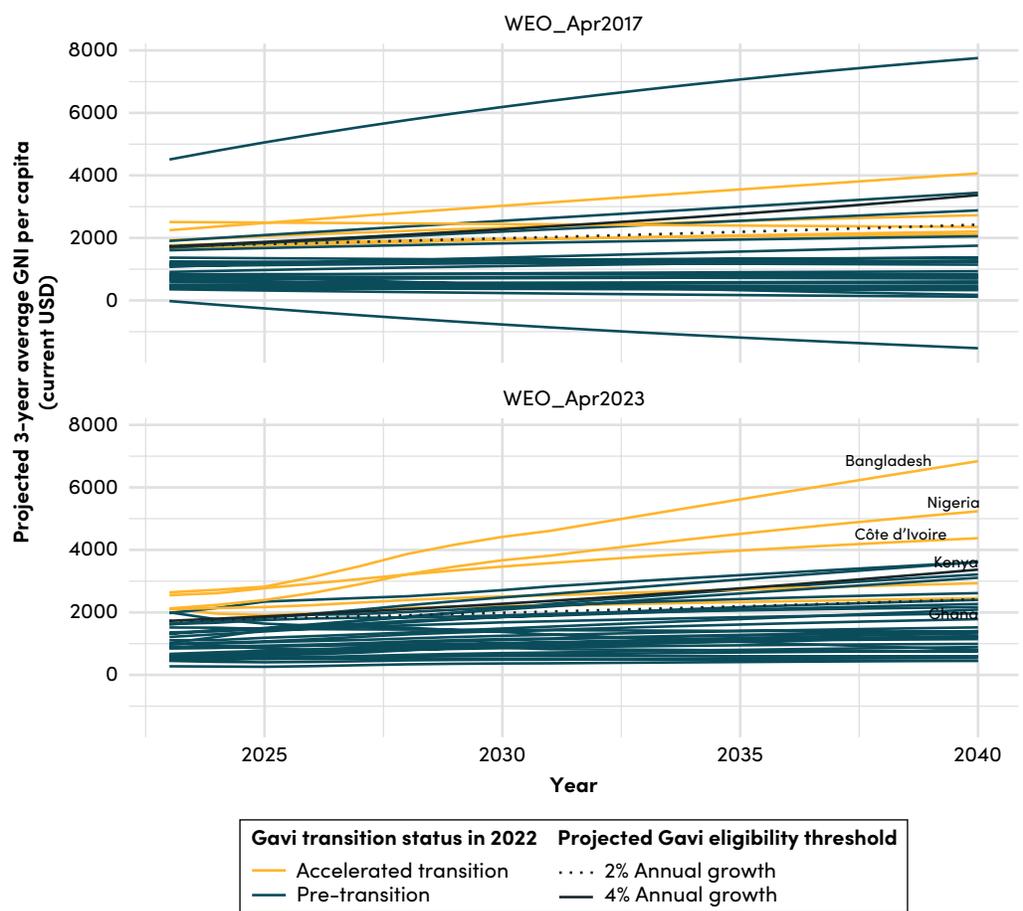
Economic Data Source	Evolution Against the Eligibility Threshold Between 2023 and 2040	Number of Countries (% of Current Disbursements in Each Mechanism)		
		Gavi ^a	GFATM ^b	IDA ^c
WEO April 2017	Backslide: above threshold in 2023, below threshold in 2040	6 (14%)	–	–
	Transition: below threshold in 2023, above threshold in 2040	–	1 (< 0.1%)	4 (2%)
	Stay above: above threshold in 2023 and staying above in 2040	6 (11%)	1 (< 0.1%)	17 (16%)
	Stay below: below threshold in 2023 and staying below in 2040	38 (58%)	95 (97%)	32 (45%)
WEO April 2023	Backslide: above threshold in 2023, below threshold in 2040	5 (6%)	–	–
	Transition: below threshold in 2023, above threshold in 2040	1 (< 1%)	10 (1%)	12 (22%)
	Stay above: above threshold in 2023 and staying above in 2040	8 (18%)	1 (< 1%)	20 (18%)
	Stay below: below threshold in 2023 and staying below in 2040	37 (59%)	87 (96%)	21 (23%)

Notes: a) Figures for Gavi assume a 4% annual increase of the eligibility threshold. b) Figures for GFATM consider only the high-income threshold and not the disease burden criteria, which are discussed in Section 3.3. c) Figures for IDA do not consider creditworthiness and other criteria (e.g., small island economy exception). In the WEO April 2017 release, no economic data were available for Somalia and Eritrea. Percentages do not add up to 100% by column for two reasons: some IDA projects are regional, not country-specific; and some countries were excluded from the analysis, as explained in Section 2.

TABLE 5. LMICs included in the analysis that received disbursements in both 2019 and 2020 from at least one of Gavi, GFATM, or IDA

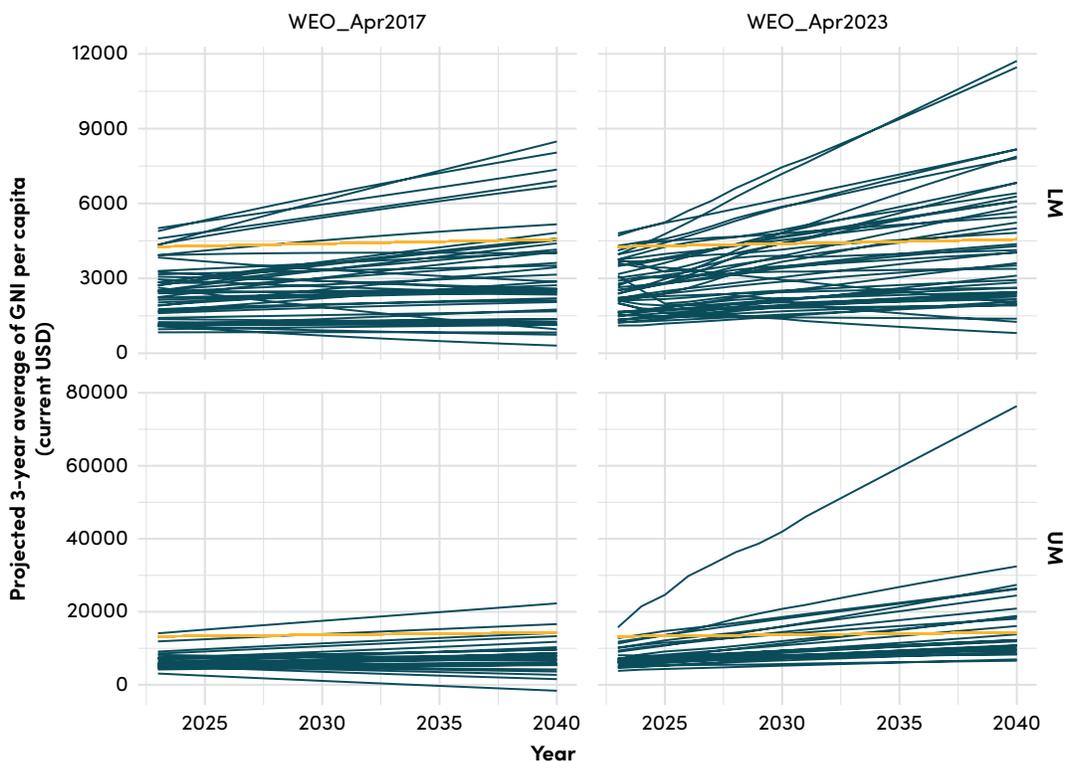
Mechanisms	Number of Countries by Income Group (World Bank, July 2019 Release)		
	Low (n = 26)	Lower-Middle (n = 46)	Upper-Middle (n = 32)
Gavi only	–	–	–
GFATM only	–	13	28
IDA only	–	1	3
Gavi and GFATM	6	4	–
Gavi and IDA	1	–	–
GFATM and IDA	–	7	1
Gavi, GFATM, and IDA	19	21	–

FIGURE 5. Projected three-year average GNI up to 2040 for Gavi top recipient countries based on pre- and post-COVID-19 economic data



Note: Only countries in accelerated transition are labeled.

FIGURE 6. Projected GNI per capita up to 2040 for GFATM-recipient countries



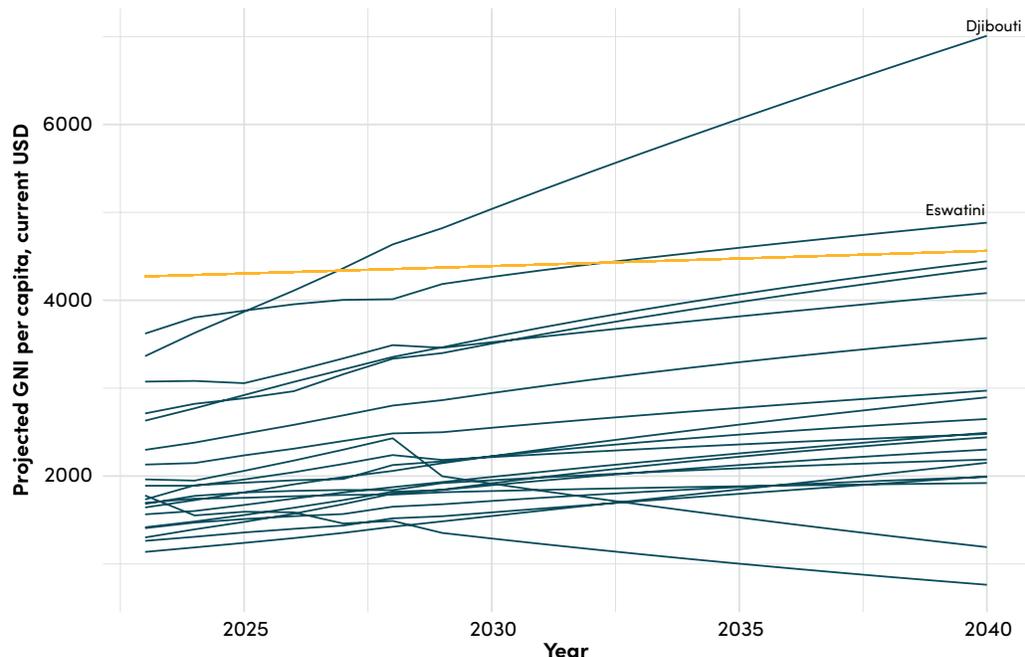
Notes: Income groups based on World Bank, July 2019 release. Gold lines denote projected income group thresholds based on past observed growth.

TABLE 6. Disease burden indicators for GFATM eligibility criteria in countries projected to transition to upper-middle-income status by 2040

Country	GFATM Disbursements as a Share of Current Health Expenditure (%) ^a	Disease Burden Criterion/a met ^b
India	0.2	Share of global malaria deaths (%) > 0.25 (~1)
Nigeria	1.7	Malaria cases per 1,000 persons at risk > 65 (292) Deaths from malaria per 100,000 persons at risk > 12 (49) Share of global malaria deaths (%) > 0.25 (~31)
Philippines	0.3	TB incidence per 100,000 population > 50 (650)
Djibouti	5.1	TB incidence per 100,000 population > 50 (204)
Eswatini	5.7	HIV prevalence > 1% (~28)
Papua New Guinea	3.4	Malaria cases per 1,000 persons at risk > 65 (184) Deaths from malaria per 100,000 persons at risk > 12 (36)
Bangladesh	0.6	TB incidence per 100,000 population > 50 (221)

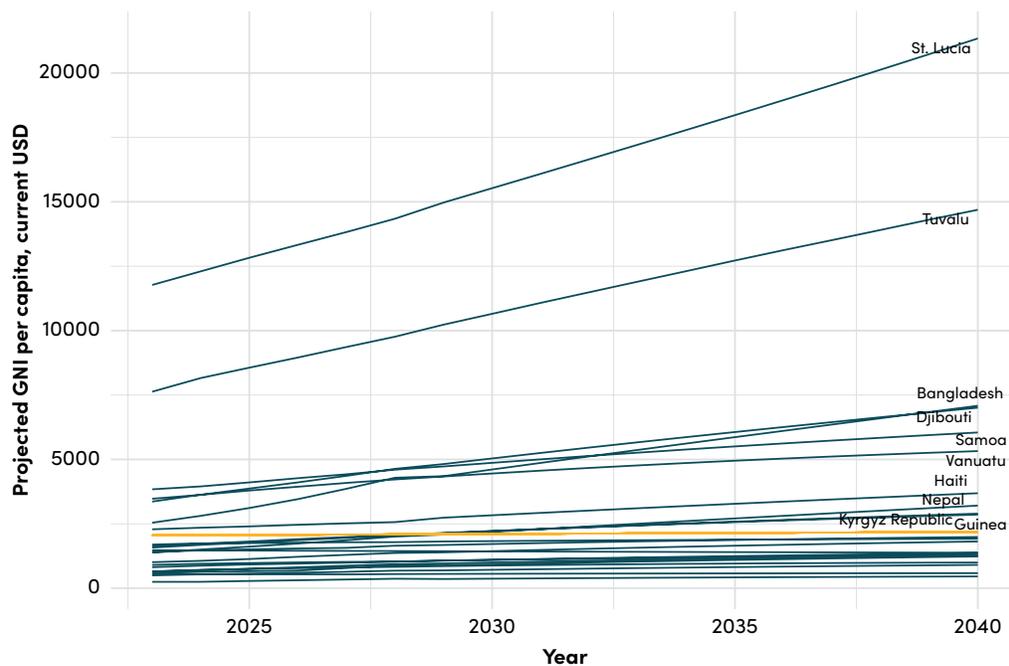
Notes: a) Average over the interval 2017–2019. b) TB incidence and HIV prevalence data from World Bank Open Data, latest year available, <http://data.worldbank.org>.

FIGURE 7. Projected GFATM eligibility for lower-middle-income countries where GFATM disbursements currently exceed 2 percent of current health expenditure, 2023–2040



Note: Gold line denotes projected lower-middle to upper-middle income threshold based on past observed growth.

FIGURE 8. Projected IDA eligibility for countries where IDA disbursements currently exceed 2 percent of current health expenditure, 2023–2040



Note: Gold line denotes projected IDA eligibility threshold based on past observed growth.

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