

Reimagining Global Health Financing

How Refocusing Health Aid at the Margin Could Strengthen Health Systems and Futureproof Aid Financial Flows

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Abstract

Health aid has helped domestic financing achieve historic gains in global health but there is much still to be done. Six major issues currently prevent aid from being more effective, fit for the future, and aligned with country priorities, namely: funding volatility, aid fragmentation, the displacement of domestic finance, ineffective prioritization, the lack of transition planning, and the lack of country ownership.

We propose a new model that aims to address these challenges: that domestic finances should support essential health services and health aid should primarily be used to expand the package of affordable services *at the margin*. Instead of targeting the most cost-effective interventions, donors should support countries to have strong and effective prioritisation processes and direct any additional financial support for health services to those that would otherwise not be covered by domestic funds. A marginal aid approach would address issues of volatility, fragmentation, and fungibility, and encourage better planning and prioritisation by countries and donors, leading to more overall health for the money. As countries' health financing improves, health aid focused at the margin is naturally crowded out, offering a seamless aid exit strategy for thriving countries and ensuring the sustainability of financing for countries that continue to need support. Perhaps most fundamentally, a marginal aid approach empowers national decision makers and national policy processes.

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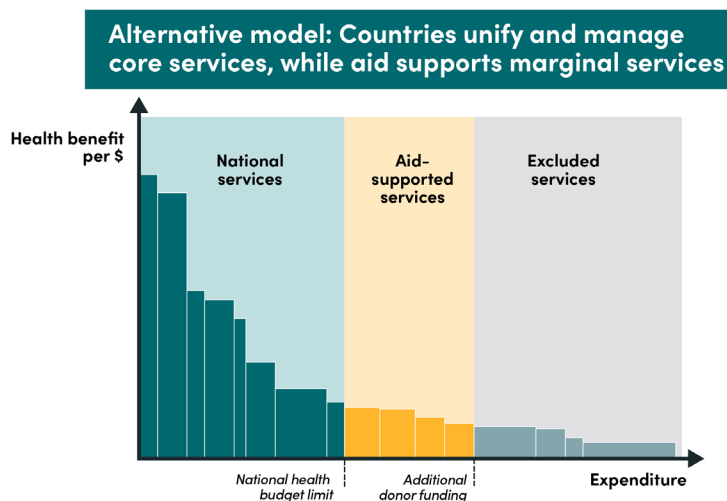
Summary

Health aid has supported domestic financing in achieving historic gains in global health: deaths from infectious diseases have plummeted, giving birth is safer and life expectancy has risen to 73.5 years. However, there is much still to be done and, with respect to financing service delivery, there are six major issues holding back aid from being more effective, better prepared for the future and better aligned with recipient country priorities:

1. At the programme level, health aid is **volatile**. Funding streams for essential services can dry up as donor interests shift or funding flows reduce.
2. Health aid is **fragmented** across myriad organisations and channels, creating enormous administrative burden for recipient countries.
3. Health aid can **displace domestic finances** meaning donors are not truly creating the change they intend.
4. Health services are often **not effectively prioritised** to produce more health for the money.
5. There is little planning for an appropriate and equitable **aid exit strategy**.
6. Countries are not free to **set their own priorities**. Beyond the administrative challenges is the democratic principle that decisions on public services should be made locally, not in DC, Geneva, London or any other country.

To address these fundamental issues, we propose that domestic finances should support essential health services and **health aid should primarily be used to expand the package of affordable services at the margin**. That is, the core package of the highest priority most cost-effective services should be fully supported by domestic finances. Instead of targeting the most cost-effective interventions, donors should support countries to have strong and effective prioritisation processes and direct any financial support for health services to the next-most-cost-effective interventions—i.e., those that would otherwise not have been covered by domestic funds.

Health interventions ranked by cost-effectiveness



As well as addressing the fundamental aid issues of volatility, fragmentation and fungibility, a marginal aid approach would encourage better planning and prioritisation by countries and donors, leading to more overall health for the money. As countries' health financing improves, health aid focused at the margin is naturally crowded out. This therefore offers a seamless aid exit strategy for thriving countries, which, in turn, ensures sustainability of financing for countries that continue to need support. Lastly but perhaps most fundamentally, the approach empowers national decision makers and national policy processes.

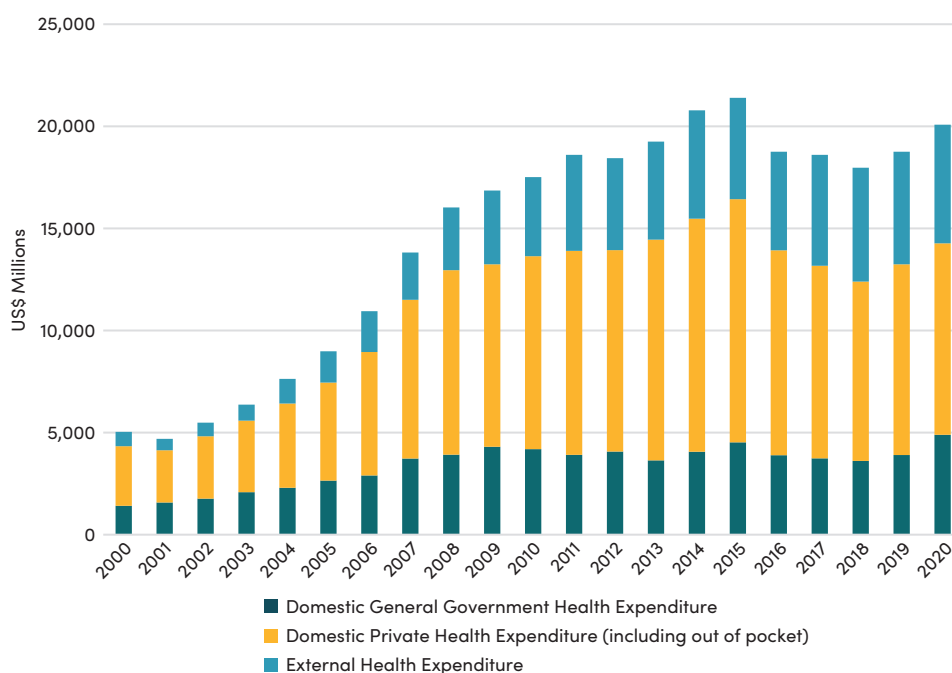
In the post-Covid era, tightening fiscal pressure on health aid and recipient countries makes reforms towards effective, coherent, and country-led health service financing only more important.

Global health financing and its discontents

Recent decades have seen unprecedented improvements to the health of people living in low- and middle-income countries. Between 2000 and 2017, maternal deaths per 100,000 live births dropped by 38 percent worldwide (WHO, 2019) and 50 million lives have been saved over 20 years due to programmes to combat HIV, tuberculosis, and malaria (The Global Fund, 2022b). Global life expectancy at birth has increased from 51 years in 1950 to 65 years in 1990, 67 years in 2000 and 73.5 years in 2019 (Abbaftati et al., 2020).

Health aid¹ has also increased significantly in recent decades and on average comprises approximately a quarter of total health spending in low-income countries (Micah et al., 2021) (see Figure 1 for breakdowns) with higher proportions in countries such as Malawi (44 percent) and South Sudan (55 percent) (World Bank, 2022). Despite the huge gains aid has helped facilitate, there are issues with the effectiveness, or even negative impacts of, health aid (Moon & Omole, 2017). We identify six key issues: volatility, fragmentation, the undermining of country autonomy, ineffective prioritisation, lack of transition planning and crowding out of domestic finances. Post-Covid, addressing these issues will become more urgent, as fiscal pressures increase, both on health aid and on public finances of recipient countries (Gupta & Sala, 2022).

FIGURE 1. Health spending by source for low income countries, 2000–2020



Source: WHO Global Expenditure Database.

1 The financial and in-kind resources dispersed through major development agencies to low- and middle-income countries for health known technically as Development Assistance for Health.

Volatility

The total health aid received by each country is somewhat stable year on year (Hudson, 2015) but this masks programme-level volatility in funding for specific services. As donor programming is commonly done through a three-to-five-year cycle, in a best-case scenario, many aid-funded services can expect disruption every few years. Indeed, the implementation of aid programmes is delayed by months or even years after business cases are approved. Donor priorities are also volatile resulting in sudden changes in funding streams, from major bilateral cuts (Regan & Baker, 2021) such as the UK FCDO cutting bilateral funding to African countries by 50 percent from 2021 to 2022 (FCDO, 2021), or policy changes due to donor country political landscape, such as all funding for family planning being pulled during the US Trump presidency (Starrs, 2017). This instability has far-reaching effects for many core services in recipient countries. Short-term and changing funding commitments make it difficult for countries to manage health systems to consistently provide high priority high-cost effectiveness core services in a sustainable way for their populations (BenYishay et al., 2022). This occurred in the Democratic Republic of Congo, to give one specific example, when donors pulled their performance-based financing scheme for health care workers, creating issues with access to services for their population (Maini et al., 2019).

Fragmentation

There is a bewildering array of global health donor organisations and mechanisms that health administrators in recipient countries must navigate. The transaction costs of dealing with a large number of piecemeal income streams is a deadweight on a country's health system administrators and impedes their ability to take control of the health system and establish effective national processes and institutions. At the country level it can be, if anything, more complex. A recent public expenditure review in Tanzania found that in 2017 alone, there were 504 vertical projects funded by development partners, most of which provided only a small amount of support (World Bank, 2020).

Fragmentation of global health aid is widespread, but a particular problem where there are too many donors in an area, either due to a lack of donor coordination, problems of accountability or issues of power relations (Spicer et al., 2020). The result is that health officials in recipient countries must spend significant effort navigating the various offers of health aid and therefore have less time to manage the health system. Excessive fragmentation can be especially damaging in countries with smaller populations, as seen in the small islands in the Pacific who contend with very high levels of project related aid (Wood & Nicholls, 2021).

Fragmentation can also cause political challenges within countries, as those who are involved in providing vertical programmes may have little incentive to integrate into national health systems. Vertical programmes are usually well-funded, have good monitoring and evaluation systems, commodities are often provided directly and there is sufficient resourcing of health care workers. For example, in Kenya, there is a reluctance from those running vertical programmes to integrate

into national systems for fear they will lose capabilities or be forced to scale down operations, and therefore potentially lose progress made (Chi & Regan, 2021).

Crowding out of domestic finances

While health aid is additional funding provided to a country, often for a specific purpose, it can have the unintended consequence of displacing domestic health financing (Leiderer, 2012). This can translate to the aid received for specific health programmes making resources available for other health programmes, or even diverting what would otherwise have been government health expenditure towards non-health sectors. It has been estimated that every US\$1 of health aid spent, domestic health expenditures reduced by \$0.43 to \$1.14 (Lu et al., 2010). While some note that increased spending on other public services is likely to still benefit a country's development (Martínez Álvarez et al., 2016), at the very least it means donors are not really buying what they think they are.

Ineffective prioritisation

A crucial element of any health system is the ability to allocate resources towards services that will provide the most health (or other valued outcomes, such as protection from catastrophic health costs) for the money. Decision makers therefore need effective priority setting processes to aid in resource allocation, but many lower income countries must work with less established processes for prioritisation. This results in many low- and middle-income countries (LMICs) falling either into implicit rationing—with scarcity of funds and lack of prioritisation resulting in *ad hoc* service provision—or investing heavily in flashy but poor value services, rather than evidence-informed decisions on the most cost-effective services available. The presence of aid in support of certain services makes prioritisation by country administrators even harder as it means when trying to optimise a health benefits package, only certain pieces of the puzzle can be moved.

For donors, equitable allocation of health aid globally is a fundamental challenge. International donors have the power to choose which health areas or interventions to prioritise. This can be baked into the founding mandate of an organisation; The Global Fund, Gavi, PEPFAR, UNAIDS and so on. Or it can be part of the design of specific programmes for either multilateral or bilateral funding. The degree to which such priorities are evidence-informed, political or opportunistic will differ from programme to programme. Unlike organisations focusing on domestic issues, international donors also have the choice in how to allocate investments between countries, based on a balance of need, politics, and perceived windows for change, but these interactions can also lead to unequal allocations resulting in so-called donor darlings and orphans (Davies & Klasen, 2019).

Lack of transition planning

As countries income levels rise, low- and middle-income countries face the prospect of a transition from donor aid (Sabino et al., 2020). While this is generally good news as these economies are

growing, donors reducing health aid to countries without a clear health aid exit strategy can risk being *ad hoc* and inequitable. Without proper transition planning, it can result in services being cut, leaving gaps in access and possibly permanent scarring through loss of health care staff as funding dries up. For example, when Romania transitioned to a middle-income country, the Global Fund stopped providing ~US\$26.4 million in HIV funding, resulting in a collapse of critical services, that led to a spike in the prevalence of HIV among people who inject drugs from 1.1 percent in 2009 to 53 percent in 2013 (Flanagan et al., 2018). Shifting donor priorities and tightening aid budgets exacerbate this trend and means countries transitioning away from dependence on donor aid for health spending need to be supported. Coordinated action is critical to ensure transition does not hinder the progress made in these countries.

Lack of country ownership

Many of the above issues with health aid are related to a lack of ownership for the recipient country over the assistance they receive. Donors have distinct interests and navigating how these preferences relate to the recipient countries' national priorities means work to reconcile fragmented and potentially volatile financial support and requires national decision makers to fit domestic finances around health aid. However, health aid is problematic not only because of these practical challenges; by attaching their own preferences and conditions to funding they effectively undermine the power of national authorities to set priorities and therefore weaken the social compact with their constituent public (Guiteras & Mobarak, 2015). Lack of country ownership is a pervasive issue in contemporary health development discussions (Hasselskog, 2022).

Donor priorities include the creation of major institutions, for example the Global Fund, GAVI, and other multilaterals, who have their mission built into their function and often have enough political sway to affect national priorities in their favour. Even in scenarios where the country is in the leadership position, such as Global Fund Country Coordinating Mechanisms, donors still set the major parameters (i.e., which diseases can be funded), and provide can give formal or informal steers on what they are looking to see in proposals. Analysis has found in Ghana this set up limits the realisation of country ownership, with the Global Fund exercising significant influence in the domestic priority setting space (Onokwai & Matthews, 2022).

Bilateral aid can appear as an alternative to multilaterals in order to put more ownership back towards the recipient countries but earmarking of funds for donor priorities remains very common and restricts the freedom of national policymakers. Historically, direct budget support has been used by donors to give recipient countries greater ownership over the use of funds (Williamson & Dom, 2010). However, as these funds were not strictly allocated to programmes or outcomes, and some countries have weaker financial management systems there were concerns about the risk of misuse or misappropriation and therefore this type of support is a much rarer form of investment in recent years (Kolstad, 2005).

BOX 1. Efforts to improve health financing in low- and middle-income countries

Sector-wide approaches

First developed in the early 1990's Sector-wide approaches (SWAs) brought government, donors and other stakeholders together to pool donor funding and “provide a more coherent way to articulate and manage government-led sectoral policies and expenditure frameworks and build local institutional capacity” (Peters et al., 2013a). Since then, more than 30 recipient countries have set up SWAp agreements with development partners (Sweeney et al., 2021). SWAs have the potential to improve aid effectiveness (Woode et al., 2021), enhance country ownership (Sweeney & Mortimer, 2016), reduce the crowding out of domestic finances (Sweeney et al., 2017) and smooth aid volatility. While there have been success stories (Isabekova & Pleines, 2021), in some cases, results have been disappointing (Udechukwu et al., 2021), and SWAs continue to have mixed support as mechanisms for health aid spending. A limitation of SWAs is often the lack of a clear framework for how and what kind of support donors should give, and they can only work as designed if they have high levels of buy in and support from donors and governments. Major donors such as the US rarely joined SWAs, others such as the UK selectively bypass SWAs if they lack confidence in the government, and disease specific initiatives such as the Global Fund tend to circumvent them as they lack the focus on their priorities (Peters et al., 2013b).

Multilateral funds

Multilateralism is the alliance of multiple countries in pursuit of a common goal. Multilateral global health funds involve the pooling of health aid from multiple states (and sometimes private philanthropic sources), with the aim of harmonising financing of a particular goal. The specifics of how such funds operate varies greatly. Some multilaterals such as the Global Fund focus on high burden diseases with potential for major improvements, and so work well to galvanise international support, creating powerful mechanisms for directing aid towards agreed objectives. Others, such as the World Bank's Global Financing Facility (GFF) have a broader remit to support the health system and actively work with countries to set priorities which does substantially reduce fragmentation and volatility, though ultimately has been shown to create siloed processes, and parallel priority setting systems (Silverman et al., 2020).

Many multilaterals have a focussed remit with a limited scope, some of which were arguably created in response to the SWAs, which did not cater to targeted responses to emergencies (Peters et al., 2013b). Several of these funds have relied on vertical delivery of programmes that are run in parallel to broader primary and secondary care services, often with limited integration.

So, while there is less fragmentation of financial flows, there is still unhelpful fragmentation of health systems which can lead to issues of coordination and sustainability (Regan et al., 2021). These vertical initiatives can contribute to aid fungibility by displacing local finances and human capital. Multilaterals also have the power to distort local priorities; as noted above, The Global Fund's focus on HIV/AIDS, malaria and tuberculosis can restrict local priority setting processes as decision makers are less able to consider trade-offs between health areas or move money between health areas. Such key decisions being made far from local context can also create interest groups in countries that are aligned with the multilateral, for example HIV programmes separate from national public health institutions in countries with their own dedicated external funding stream.

Evidence-informed priority setting

Effective health systems broadly prioritise spending towards services that deliver the most health for the money. Knowing which services to include in the health benefits package offered requires processes and capabilities for assessing the relevant costs, effects, and other relevant evidence (Glassman et al., 2017). Strong Evidence-Informed Priority-Setting (EIPS) systems deliver more health for the money (Barlow et al., 2022) and can strengthen Ministry of Health (MoH) leadership while establishing a sense of fairness and openness for which services are publicly funded and why. Centralised national EIPS systems can improve the impact and donor confidence in SWAPs, and can, in theory ensure proposals to multilateral funds such as the GFF and GF are coherent and high impact. In reality, however, most GFF proposals do not use national EIPS systems and evidence (Madan Keller et al., 2021), and fragmentation of health financing means decision makers are often trying to optimise a package around earmarked aid funding for selected services.

To differing degrees, donors also use evidence to inform decisions on the allocation of health aid, including considerations of value for money (CGD, 2014), a guiding principle historically championed by the UK government's former Department for International Development (DFID, 2011). In recent years, the rise of the effective altruism movement had precipitated a greater focus on how philanthropy can do the most good for the money given (Open Philanthropy, 2023) and organisations such as GiveWell encourage philanthropic giving to the things that can produce the greatest social value in low-income contexts (GiveWell, 2022). This encourages donors and NGOs to demonstrate the effectiveness and cost-effectiveness of their programmes. However, once the highest value services are identified, this raises the question; is external funding actually the best way to provide for these high-impact, core services rather than domestic financing?

Putting aid in its place

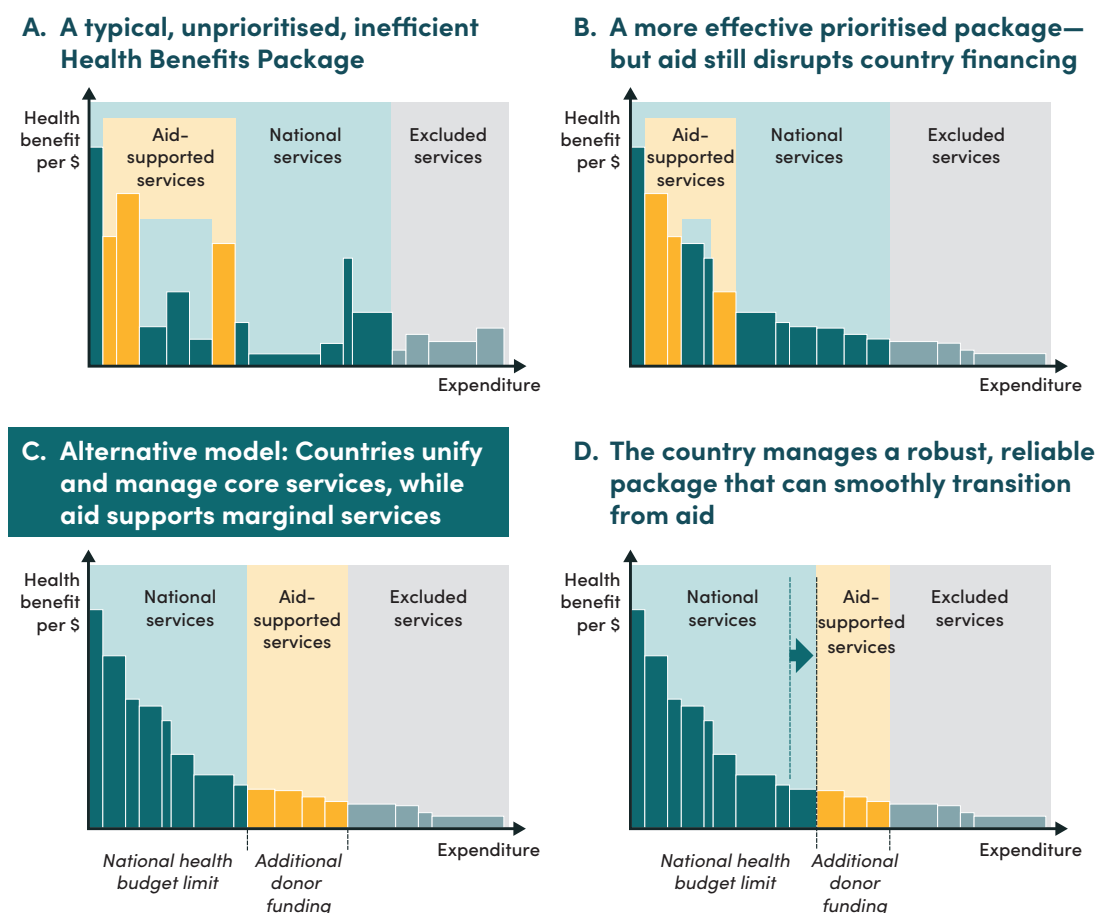
Various strategies and approaches have been proposed (Lane & Glassman, 2008) and deployed in an effort to improve global health financing and the effectiveness of development assistance. We describe some of these solutions, and their associated shortcomings or drawbacks in Box 1. These efforts are not mutually exclusive and have yielded some significant successes, but the six major challenges we identify, remain.

Marginal aid

Here we outline an approach to global health financing that, by combining evidence informed priority-setting with a refocusing of health aid on marginal investments, has the potential to substantially improve the six issues described above, and fill the gaps of previous solutions to these issues. The fundamental proposal is a new health financing compact between government and donors. Aid would not be used to finance the most cost-effective or otherwise highest value services, nor to support services that reflect the preference of the donor. Instead, domestic financing would support the highest priority services and aid should be used to support the next-most-cost-effective or next highest priority services; those services which are just out of reach of a well-prioritised and appropriately funded national MoH. Where funding is earmarked for certain diseases, it should still not displace core funding, but only add to that disease package at the margin.

At the core of this health finance restructuring is the ability to assess the expected costs and effects of health investments and set up a single national health benefits package that is aligned with the total expected health budget from domestic and aid sources. Both recipient countries and donors will need to place greater emphasis on evidence informed priority setting and work towards strengthening relevant systems and processes. Recipient countries will be in the driving seat with donors supporting the strengthening of evidence systems if necessary. Figure 2 illustrates a health benefits package with services prioritised by their cost-effectiveness and aid support focused on expanding the package of affordable services (Panel C). This is developed further in terms of cost-effectiveness threshold theory elsewhere (Drake et al., 2023).

FIGURE 2. Illustration of prioritised health benefits package with aid investment at the margin



Notes: Panel A: Poorly prioritised HBP. Panel B: Well prioritised HBP with aid supporting core services. Panel C: Well prioritised HBP with aid supporting marginal services. Panel D: Growing domestic finances crowd out health aid.

In this paper we use intervention cost-effectiveness as a shorthand for services that yield the greatest gains for the resources required. In technical economic evaluations this often refers to some cost per unit of health but in broader evidence assessment processes, other non-health gains or distributional consideration might be weighed as well. These other considerations will to some extent reflect the preferences or values of the national institutions and decision makers and therefore the country's prioritised ranking of services may differ from what a donor would consider optimal. Up to a point, we suggest that donors should accept the prioritisations developed by countries, if following a clear process for establishing criteria for prioritisation and conducting rigorous analysis and appraisal to set priorities based on these criteria. However, there may be circumstances where a donor does not have confidence in the process that developed the expressed priorities of a country. This is a significant challenge to the marginal aid approach. More generally it may mean a genuine, trust-based, health financing compact between donors and country policy makers is untenable for now. We return to this in limitations section.

Potential benefits

The benefits of shifting to a marginal aid approach are potentially widespread and profound. The approach has the potential to radically improve health financing by addressing the six key challenges outlined above. Firstly, allowing domestic financing to take its natural place and support the most-cost-effective, highest priority services, would avoid the volatility of donor support, protecting the core of the national health benefits package. Services that provide the most health for the money, such as vaccination, would no longer be vulnerable to the vagaries of donor programme cycles.

Second, by providing a clear framework for what donors could support, a marginal aid approach would facilitate pooling of donor resources, strengthen SWAps and reduce fragmentation of financial flows. An underlying driver of fragmentation is that donors have a wide range of options of what to fund. If donors and countries agree on a clear collective process of identifying appropriate marginal interventions, donor choice is then restricted to these investments, making donor harmonisation easier and reducing the burden on country leaders and administrators.

Third, in focusing on services at the margin, health aid would be far less likely to crowd out domestic financing. The role and scope of domestic financing would be clearer to both country populations and donors. Indeed, depending on how marginal aid is structured, it may be able to incentivise additional domestic financing of health. For example, if donors offer a subsidy (Morton et al., 2018) for marginal services, this may make them sufficiently attractive for further government investment. In addition, by supporting EIPS, Ministries of Health will be empowered to show Ministries of Finance that the resources are being used well, potentially increasing domestic spending on health.

Fourth, the marginal aid approach brings donors and domestic policy makers together to support rather than undermine national priority setting. Effective evidence informed priority setting is central to successful marginal aid and strengthening of such systems has been shown to yield more health for the same money (Barlow et al., 2022) with an estimated 8-fold return on investment in Thailand (Kingkaew et al., 2022). Therefore, improved global health financing based on principles and processes for good quality evidence use, can be expected to have a strong beneficial effect on the results from *both* domestic and international financing.

Fifth, beyond getting more bang for the buck, a marginal aid approach offers a clear and predictable framework for transition planning and an aid exit strategy, without jeopardising core services. In Figure 2 Panel D, the blue section on the left represents expanding domestic resources, naturally crowding out aid financing or potentially making it possible for aid to support further interventions. However, the marginal aid approach also offers a potential rational justification for allocation between countries, topping up each country at the margin up to a certain global standard (Drake, 2014), and freeing up resources from growing economies towards countries with greater needs. Further elucidation of this is beyond the scope of this paper but will be explored in subsequent papers.

Last, and perhaps most crucially, the marginal approach puts the power squarely with recipient country leaders to establish the priorities for both domestic financing and health aid. A clearer framing of domestic resources and decision makers as primary and donor resources and decision makers as secondary, has both practical and political importance. Practically, agreeing that donor financing for health services will focus on top-up support to the next-most-cost-effective interventions, means country governments can focus on strengthening a cohesive package of services supported by domestic finances and take the lead on identifying priorities for donor support. Politically, refocusing donor financing at the margin better reflects the auxiliary role of aid in LICs and aligns with the wider localisation agenda in global health.

TABLE 1. Health aid challenges and potential benefits of a marginal aid approach

Health Financing Challenges	Benefits of Marginal Aid Approach
<p><i>Volatility.</i> Health aid is inherently unreliable. At the programme level financial support for high priority services might last for a few years before the donors’ priorities change. At the aggregate level the combined amount of aid received by a country can also rise and fall and is beyond the control of country decision makers.</p>	<p>Allowing domestic financing to focus on the core package protects the highest priority services from the fluctuations of aid investments.</p>
<p><i>Fragmentation.</i> Health aid is split across myriad different initiatives from multiple donors, often earmarked for specific disease purposes.</p>	<p>Health aid is consolidated into a more cohesive and manageable offer meaning country health leaders and managers are freed up to manage the health system rather than managing aid arrangements.</p>
<p><i>Crowding Out Domestic Finances.</i> While health aid is often clearly directed towards specific services, in some cases, in the absence of aid, domestic funds would be used to ensure the service is provided. The upshot in such a scenario is that health aid did not effectively provide access to the intended service but allowed the national government to finance something else instead. Many LMICs do not prioritise health spending, possibly in response to substantial health aid over many years.</p>	<p>Health aid is clearly and specifically directed towards valuable health services that would otherwise not have been prioritised for investment by the national MoH. MoH is empowered through EIPS to negotiate for more resources with Ministry of Finance. Moreover, subsidising marginal investments (rather than fully paying for them) may crowd-in domestic financing (Morton et al., 2018).</p>
<p><i>Ineffective Priority-Setting.</i> In many LMICs the use of evidence in prioritisation of health services could be improved or there is widespread implicit rationing.</p>	<p>Priority setting systems will be strengthened through this approach, yielding more health for the money from both domestic and external sources.</p>
<p><i>Lack of Transition Planning.</i> As some historically weaker economies begin to thrive donor countries and philanthropies are likely to want to reduce health aid and do so in a fair way that is not disruptive to recipient countries. Moreover, International donors have choice not only about which interventions to prioritise but how to allocate investments between countries.</p>	<p>There is a clear and fair mechanism for reducing aid as poorer countries income grows or total health aid fluctuates. A marginal aid approach offers a potential rational justification for topping up each country countries to achieve a certain minimum standard. This could sustain financing for other countries, even countries which do not switch to a marginal aid approach.</p>
<p><i>Lack of country ownership.</i> A subtle but important reality of countries receiving extensive health aid is that decisions on health priorities are often made in donor countries rather than by country leaders.</p>	<p>Recipient country leaders have greater powers to determine the health priorities for the populations they represent.</p>

A marginal approach in practice

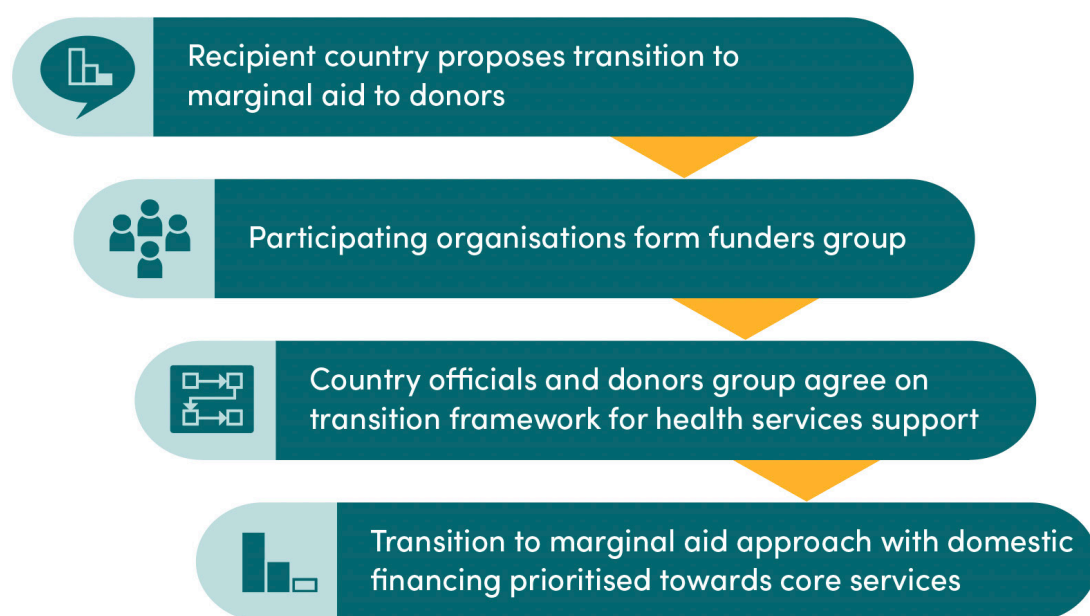
A marginal aid approach requires substantial trust and coordination between partners and government and strengthened priority setting capabilities. A realistic approach may build on existing health financing coordination structures including SWAps and possibly multilateral funds. An effective SWAp partners forum could be an ideal place to agree to adopt a marginal aid approach to targeting health aid rather than more pragmatic or opportunistic approaches. We can also imagine multilateral funds adopting a marginal aid approach. This could be an evolution of the current ways of working, within the scope of their current mandate. For example, the global financing facility (GFF) already co-creates an investment case with governments building on existing mechanisms, to prioritise and jointly invest in cost-effective interventions for maternal, child and adolescent health and nutrition. Disease-specific initiatives such as the Global Fund may find joining marginal aid approach more feasible and attractive in countries were transition planning, co-financing or joint financing with another funder (e.g., World Bank in Laos (Morton et al., 2018)) is seriously underway. More ambitiously, a multilateral fund could radically revise its mandate to adopt a marginal aid approach. “Team Europe” (Capacity4dev, 2022) donors could also consider pilot working together to support a marginal aid SWAp, which would nicely demonstrate the value of their collaboration. Given the UK’s unreliable and falling bilateral funds, and its renewed commitment to HSS (Drake & Baker, 2021), officials may also want to support such an integrated approach to stabilise and improve the impact of its financial support.

A marginal aid approach will not be applicable in all countries that receive health aid and the decision to switch to a marginal aid approach should be led by recipient country decision makers. At the national level, this decision may depend on the degree of health financing; whether donor financing fragmentation and volatility is considered problematic by country leadership; the strength of priority setting systems and processes; whether there is appetite for major reforms given the national political economy; and the willingness of a sufficient number of donors to support the transition to a marginal approach. At the global level, this transition to financing at the margin would require a major effort from multilateral funds, bilateral state donors and philanthropies to adapt their ways of working. In many cases, these organisations rely on being able to claim huge public health impacts (The Global Fund, 2022a) based on their funding of what are often, but not always, the most cost-effective health services. The marginal approach is a partial challenge to the effective altruism approach, but only in the specific arena of financing health services. Philanthropic investment in global public goods, for example through research and development of new health technologies, should still seek the greatest bang for buck. Even support to health services should still think centre cost-effectiveness, but while better recognising the role of philanthropy as an auxiliary actor.

What might a transition to a marginal aid approach look like? It is a core component of the approach that the process should be country-led and so the formal expression of interest for a transition towards a marginal aid approach must come from the country. They are likely to want to convene a country level health development partners group, if there is not already an existing country level

forum. The country government and donors will need to agree a country-specific framework for a marginal aid financing and the country may request technical support to strengthen priority setting capabilities. At such a time that the country believes it has achieved a degree of success in priority setting and has effective systems to differentiate higher and lower value, it can propose to initiate the transition to a marginal approach. This would likely lead to the preparation of a proposal to the funders group, the content of which will depend on the framework agreed but may include i) demonstrating the effectiveness of the priority setting systems ii) a reasonable budget allocation to domestic health financing that covers the core package and iii) a request for additional financing to support expanded services at the margins. The funders group would review the marginal aid proposal, potentially request further information. The funders would then agree how much additional financial support they can provide to top up the health benefits package and what financing mechanisms will be most appropriate. At the global level, donors and multilateral agencies can carry out necessary reforms to ensure their systems are compatible with this and develop global public goods such as guidance documents and case study reports as they emerge. These steps towards transition are summarised in Figure 3.

FIGURE 3. Steps towards marginal aid transition



Challenges and limitations

The major reforms to global health financing outlined in this paper would be far from straightforward and present some potential disadvantages compared with the status quo. The global health financing architecture, including major multilateral funds, donor country government departments and private philanthropies, has historically been built to target specific pre-defined interventions or disease areas. Gavi and the Global Fund for HIV/AIDS, Tuberculosis and Malaria

are two of the most prominent examples. And donor countries and philanthropies' *modus operandi* tends towards identifying what they believe would be a good investment and then engaging potential recipient countries to offer support, rather than focusing on national priorities. Moreover, accountability for good investments is often critical for donors. Just like with SWAPs and direct budgetary support, if countries are to propose the marginal services for donor support, and possibly also identify public or private suppliers, many donors will want additional due diligence measures in place. Reform to these will require significant work which would represent a substantial friction cost of switching away from previous mechanisms of support, but reform is achievable and would bring wide-ranging benefits.

In addition to the work required for change, some benefits of the current systems will be harder to maintain. Pooled funding around clear multinational priorities can allow procuring organisations to negotiate advantageous prices for health technologies (The Global Fund, 2019). With a marginal aid approach each country's marginal services will be different, undermining the ability of aid funding to negotiate prices on behalf of substantial markets. On the other hand, this deskills local procurers, who need to procure commodities not supported by a global procurer, which represent the vast majority of expenditure. These procurers continue to face substantial challenges in achieving value for money (Silverman et al., 2019), often facing monopoly suppliers and paying more than wealthy countries for the same products. Support to their reform could be a complementary additional component to marginal aid. Alternatives to this process already exist, for example regionalised pooled procurement mechanisms to support LMICs directly. For example, the African Vaccine Acquisition Trust (AVAT) is a mechanism for African Union members for centralised purchasing of COVID-19 vaccines using blended financing resources (African Union, 2021). Global health leaders could refocus on creating long-term sustainable procurement mechanisms for countries, including domestic financing, as an alternative.

Central to effective marginal aid is effective priority setting. Strengthening priority setting capabilities, while offering myriad potential benefits, is a complex health systems challenge. Marginal aid initiatives could therefore invite the support of collaborations such as the International Decision Support Initiative (IDSI), who have been working towards strengthening priority setting, particularly institutionalising Health Technology Assessment, for the last decade.

The ability for donors to point to high value investments is crucial for their advocacy. Removing the ability for the donor government of the day to boast about estimated impact of their investments in interventions like bed nets or vaccines could mean it is harder to convince the public in rich countries that ODA is an appropriate use of their taxes and therefore make it a less attractive political proposition. Similarly, philanthropic fundraising, at small or large scale, often relies on compelling narratives of just how much good can be done for relatively little money. The mission has always been to add to countries' own efforts, and so is marginal in that sense, but over the past decades this has often involved expanding the coverage (and perhaps displacing domestic funding) of the highest

value services. As global development learns and improves, donors should redesign their support to allow countries to develop appropriate long-term national systems. New narratives for advocacy may be needed and the claims of lives saved may have to be more modest with the marginal aid approach. In reality, of course, political support for development spend has always relied on a coalition of supporters, brought together by many different arguments, including national self-interest (Calleja, 2019). A rational appraisal of the comparative value for money was only ever a small part. Alternative narratives based on marginal aid may help resolve this tension and rebuild a new coalition: that of decolonisation, empowerment, and country self-reliance which could be attractive to governments across the political spectrum.

Finally, this proposal has assumed, incorrectly in some cases, that governments are benign social planners. In many instances high priority services for excluded minorities may not be funded if left to domestic resources only. Historical examples include tuberculosis treatment in Russian prisons (MSF, 2002) and HIV treatment for stigmatised and criminalised key population groups (such as sex workers) in most countries around the world. These may be situations where donors decide it is necessary to abandon the marginal aid approach.

Conclusion and recommendations

Conceptually, shifting to a financing model where domestic finances are allocated “first”, and aid is allocated as top up is relatively simple and reflects the reality of what aid is arguably intended for. At the same time, the practicalities of implementing such an approach are complex and the challenges in transitioning to this approach are considerable. While we recognise these challenges, we believe the potential benefits mean the approach is worth serious consideration and further detailed exploration.

To develop this proposal into an implementable plan requires overcoming both technical challenges and substantial political economy issues for both donors and recipient governments. It also substantially shifts power away from donors. To resolve these issues therefore firstly require requires an alliance of like-minded LMIC leaders, donors, researchers, and, in the long-term, normative agencies.

Below we outline how key stakeholders can support global health financing reforms and work towards a marginal aid approach:

- *Health Leaders in LMICs* who believe a marginal aid approach would be helpful can call on donors to align and pilot a framework for financing health interventions at the margin. Countries already taking a successful SWAp approach to health financing may be particularly well placed.
- *Academics and researchers* can help develop methods for a marginal financing approach. This will require developing frameworks for evidence-informed priority setting with multiple stakeholders and different payer perspectives. Related, technical assistance

providers may be needed to support countries to make this transition, and to build their capacity for EIPS. Finally, evaluators will be needed to learn lessons from the pilots and guide future implementation.

- *Global health donors*, including multilateral funds, can be proactive in considering opportunities to shift their financing ways of working to a more constructive and sustainable marginal aid approach. They can avoid prioritising their own wishes to fund, and claim credit for the impact from, the highest value services and should be responsive to LMIC requests to adopt a marginal aid approach. Donors wishing to support the development of a marginal aid approach could commission a consultative working group of policy makers, experts, multilaterals, and donors to spearhead the development of an appropriate policy framework.
- *Multilateral organisations* with normative, governance and guidance roles, can work towards developing political or expert consensus on the importance of reforming global health financing and offer guidance on best practices. For example, in 2014 the World Health Assembly agreed a statement in support of Health Technology Assessment and advocated for its role in achieving UHC. If methods for marginal aid gain traction the WHA could consider an analogous resolution. Regional organisations such as the African Union or African Centres for Disease Control could adopt similar guidance.

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