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The Inevitable Shift:

Exploring the Challenges of Domestic Resource Mobilization in Addressing the Decline in Development Aid for Health in 2025 26

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Abstract

Background The 2025–26 contraction in development assistance for health (DAH) has been widely framed as an opportunity to accelerate domestic resource mobilisation and reduce long term aid dependence. This framing is normatively attractive but analytically incomplete: it conflates a legitimate long term reform objective with the short run fiscal, institutional and operational capacity required to replace externally financed health functions.

Argument The contraction is exceptional in magnitude, speed and concentration in low income and aid dependent settings. Development assistance for health fell by 21% from 2024 to 2025, while United States financing declined by 67%. By contrast, tax capacity, budget reprioritisation, procurement systems and public sector purchasing arrangements typically evolve over several years. World Bank projections indicate that domestic government health expenditure may rise while combined government plus donor health spending still declines. Early budget reviews and country team assessments therefore point to partial mitigation, not comprehensive replacement.

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Implications Domestic resource mobilisation remains indispensable, but it should not be treated as an automatic successor to DAH. Transition arrangements require explicit fiscal feasibility tests, protected floors for essential services and commodities, phased and predictable co financing, and public verification of actual domestic additionality. Future research should prioritise the timing, distribution and mechanisms of service disruption, as well as the performance of transition compacts, rather than relying solely on contested mortality projections.

Keywords development assistance for health; domestic resource mobilisation; health financing; fiscal space; transition; universal health coverage

Key messages

1. **Withdrawal is not transition.** A transition requires an identified successor source, a credible timetable and protected continuity of services; abrupt aid loss has none of these by definition.
2. **Fiscal reform has a different time scale.** Observed tax ratio gains of roughly three to four percentage points of GDP occur over a decade, not a budget year, and only a share of new public revenue reaches health.
3. **Rising domestic expenditure is not enough.** The relevant test is whether total health resources and essential service coverage are maintained, not whether a national health budget has increased in nominal terms.
4. **Transition plans need empirical guardrails.** Co financing commitments should be conditional on fiscal capacity, verified additionality and service protection milestones, with independent review where those conditions fail.

Introduction: An Incorrect Categorization in the Transition Narrative

Domestic resource mobilisation is rightly regarded as a central foundation of universal health coverage and of the legitimacy, sustainability and sovereignty of national health systems. Over the medium to long term, countries must strengthen revenue systems, improve public financial management, reduce allocative and technical inefficiencies, and increase the priority accorded to





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health within public expenditure where fiscal conditions permit [12,13]. These objectives are not in dispute. The analytical problem arises when a long term reform imperative is treated as evidence of short term fiscal substitutability. The relevant policy question is therefore not whether domestic financing should increase, but whether governments can generate, appropriate, release and spend sufficient additional resources quickly enough to replace a sudden externally driven contraction in development assistance for health within one or two budget cycles.

This distinction is more than semantic. The 2025–26 contraction in development assistance for health is increasingly described through the language of transition, yet a transition implies an organised transfer of financing responsibility under conditions of feasibility and accountability. Comparative transition evidence emphasises that sustained coverage is more likely where transition processes are transparent, planned, integrated with domestic systems and supported by institutional alignment [14]. In a genuine transition, the successor source of finance is identified; domestic revenue, budget priority and expenditure execution pathways are credible; externally financed programme functions are mapped onto national procurement, workforce, provider payment and information systems; and reductions in external support are sequenced against demonstrable service continuity safeguards. By contrast, a withdrawal that lacks these conditions is not a transition. It is a financing shock whose effects are transmitted through commodity pipelines, implementing partner contracts, health worker employment, service delivery platforms and ultimately household access to care.

This article addresses that conceptual and empirical gap by synthesising current financing, fiscal and early implementation evidence on the short run replacement assumption. Its purpose is not to model mortality effects, since such estimates are highly sensitive to assumptions about





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counterfactual financing, programme coverage, baseline risk and the speed with which service disruptions affect outcomes. Instead, the article focuses on the prior financing question that should inform any mortality or coverage analysis: whether public budgets and health system purchasing arrangements can realistically absorb externally financed functions at the speed required to prevent service disruption. The argument advanced is that domestic resource mobilisation remains indispensable, but it cannot be assumed to operate as an automatic or immediate successor to development assistance in the absence of explicit fiscal feasibility tests, protected service floors and independently verifiable transition conditions.

The magnitude of the shock is substantial, rapid, and impacts the entire system.

The scale of the shock is not a marginal adjustment. The Institute for Health Metrics and Evaluation estimates that DAH fell from US\$49.6 billion in 2024 to US\$39.1 billion in 2025 a 21% decrease with United States financing falling by 67%, or more than US\$9 billion [1]. Sub Saharan Africa experienced a 25% fall in DAH; in Malawi and Mozambique, the reduction was estimated to equal up to 16.5% of total health spending, while Nigeria lost more than US\$400 million in absolute DAH [1]. These figures indicate exposure at a scale that cannot be understood as a normal aid transition scenario.

Multilateral replenishments point in the same direction. The Global Fund's Eighth Replenishment closed at US\$12.64 billion, below both the US\$18 billion target and the US\$15.7 billion raised for the Seventh Replenishment [2]. Gavi reported more than US\$9 billion against a US\$11.9 billion target for its 2026–2030 replenishment period [3]. The two institutions fund





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highly specified functions commodities, laboratory systems, community delivery, immunisation, HIV, tuberculosis and malaria programmes so their shortfall cannot simply be treated as fungible public revenue.

The emerging service evidence remains preliminary, but it is already consistent with system stress. WHO's rapid stocktake of country office key informants found that 75 of 106 reporting offices (71%) described disruption in at least one service area; among respondents to the relevant questions, 53% reported health worker job losses and 24% reported facility closures [4]. These figures should not be interpreted as representative facility level prevalence estimates, given the nature of the stocktake and variation in question denominators. Their importance lies in documenting plausible transmission mechanisms: funding interruptions can generate workforce losses, procurement failures and reductions in service availability before annual expenditure accounts or household surveys detect population level effects.

Domestic funding operates on a distinct time frame.

The strongest constraint is temporal. Countries that succeeded in increasing their tax to GDP ratio before moving from low to middle income status raised it by a median of about four percentage points over a decade; the World Bank estimates that countries that were able to raise tax revenue increased it by about three percentage points of GDP over a decade [5]. These are observed historical rates, not a biological or institutional ceiling. They do, however, make clear that tax system reform cannot normally yield a large, predictable health sector replacement within a single fiscal year.





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Even when general revenue increases, health does not automatically capture a proportionate share. In 2024, the median health share of government expenditure in low income countries was 6.0%, unchanged since 2018; in lower middle income countries it declined from 7.1% to 6.3% [6]. Without explicit reprioritisation, an additional dollar of public revenue may be absorbed by debt service, wages, infrastructure, security, education or social protection. This is not an argument against revenue mobilisation; rather, it underscores the need to analyse tax policy, budget priority, budget execution and health sector purchasing capacity as a single chain of replacement financing.

Debt service further narrows this chain. UNCTAD reports that Africa spent an estimated US\$70 per person on public external debt interest compared with US\$44 on health, and that 45 developing countries spent more on interest than on health [7]. In sub Saharan Africa, the median tax to GDP ratio is 13.8%, the lowest among regions [8]. Fiscal space is therefore not an unallocated reserve waiting to be directed toward health; it is a contested and often pre committed fiscal margin. The central policy question is which expenditures will actually be displaced, delayed or financed when external health resources are withdrawn.

Interpretative guardrail. Tax effort is a medium term determinant of fiscal capacity, not a same year replacement mechanism. A health financing transition should therefore be judged against the timing of cash flows, budget authorisations, purchasing arrangements and service commitments not against a generic ambition to “mobilise more domestic resources.”





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The negative arithmetic persists despite an increase in domestic expenditures.

The World Bank's 2024–2030 baseline makes the central point especially clearly. It projects that government health expenditure will increase in two thirds of countries, yet combined government and donor health spending in 2030 will still be lower than in 2024 in more than 80% of low income countries and 40% of lower middle income countries [6]. In the median low income country, domestic government health spending increases by US\$1.7 per capita while off budget donor spending declines by US\$3.9 per capita [6]. This comparison is not a literal estimate of a replacement ratio the categories and country pathways are not identical but it demonstrates why a positive domestic budget trend cannot be used to infer that aid losses are absorbed.

The policy implication is straightforward: the test is not whether a budget line rises, but whether timely, usable purchasing power for essential services is preserved. A nominal increase can still coexist with real terms erosion, delayed releases, commodity stock outs, workforce gaps, or cuts to prevention and key population services.

This is not merely an accounting issue. Donor resources are often tied to specific programme functions that domestic systems cannot instantly procure, contract, supervise or integrate. When external financing contracts, the binding constraint may be procurement lead time, foreign exchange availability, the legal status of temporary health workers, the continuity of data platforms, or the cash flow of implementing partners. A credible transition assessment must therefore trace functions and implementation pathways, not only compare aggregate financing totals.





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Initial policy actions align with a strategy of limited replacement.

Evidence from the first budget cycles should be interpreted cautiously, but it does not support the expectation of prompt, broad replacement. A review by Clements, Gupta and Ward of public budget documents for 18 of 29 highly United States aid exposed sub Saharan African countries found that none documented a concrete reprioritisation to protect health and only two proposed revenue measures [9]. This is not proof that no in year reallocation occurred: public documents can be incomplete, and budget proposals do not equal outturns. It is, however, evidence that large, visible policy shifts were not routinely encoded in the available budgets.

The IMF's 2026 regional country team survey yields a similarly qualified picture. Across 28 detailed responses, teams estimated that expenditure reprioritisation could cover roughly 30% of the funding loss; another 30% was assessed as expenditure that would no longer be needed, leaving about 40% unfunded. Twenty-three per cent of respondents reported no mitigation plan and 38% reported unresolved financing gaps [8]. Responses are self reported and may overlap, so these figures should not be read as a precise regional forecast. Their value is diagnostic: contemporaneous fiscal authorities did not expect domestic budgets to close the gap in full.

Country illustrations reinforce the same point. The IMF reports that Nigeria increased domestic health funding by about US\$200 million against an estimated US\$440 million USAID health contribution in 2024 [8]. That response is substantial, but it shows mitigation rather than full absorption; it should be read as evidence of effort under constraint, not proof that the shock has been neutralised.





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What this argument aims to achieve and what it does not.

The case for domestic financing should not be positioned in opposition to the case for development assistance. A more analytically useful framing recognises that domestic and external financing interact within political, budgetary and institutional systems. The aid fungibility literature cautions against assuming that all external health funding adds one for one to domestic public spending, while also cautioning against the opposite error: that reductions in aid will automatically generate equivalent domestic replacement. Dieleman and Hanlon found that an additional dollar of DAH was associated with a US\$0.62 reduction in government health expenditure in their historical analysis, whereas reductions in DAH were not statistically associated with an equivalent domestic increase [10]. Patenaude's analysis likewise found heterogeneous associations across programmes and country groups [11]. These findings imply that fiscal responses are mediated by political priorities, budget rules, institutional capacity and programme design, rather than by a simple arithmetic relationship between donor and domestic spending.

This distinction is central to interpreting the current shock. Historical estimates of displacement are not evidence that governments can replace a large, unanticipated and simultaneous aid contraction within a single fiscal year. On the contrary, they strengthen the case for transition arrangements that explicitly measure incremental domestic purchasing of protected functions, net of substitutions and adjusted for budget execution. In practical terms, a co financing commitment should not be judged by whether a government announces an increase in the health budget, but by whether that increase is released, spent and translated into commodities, staff, contracts and services that would otherwise have been financed externally.





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The argument is also not deterministic. Countries differ in revenue potential, debt exposure, public financial management capacity, procurement maturity, health budget priority and the degree to which externally financed services are already embedded in national systems. Some governments may be able to raise revenue, reprioritise expenditure, borrow prudently, improve execution or integrate vertical programme functions faster than others. The claim advanced here is therefore probabilistic and empirically testable: across many highly exposed countries, the speed and concentration of the aid shock exceed the historically observed speed at which fiscal capacity, budget priority and health sector purchasing arrangements tend to change. Country specific evidence should determine the pace and conditions of any transition, rather than a uniform assumption of domestic absorption.

A further implication is that aggregate expenditure indicators are insufficient for evaluating transition readiness. They obscure the institutional mechanisms through which money becomes care: procurement orders, foreign exchange access, payment to implementing partners, health worker contracts, laboratory networks, information systems and subnational distribution channels. WHO's health financing framework similarly stresses that reforms must be adapted to country specific financing arrangements and linked to budget processes and public financial management systems [12]. A country may appear to increase public health spending while still experiencing shortages of antiretrovirals, vaccines, malaria commodities, diagnostic reagents or community delivery capacity. For this reason, transition analysis should combine fiscal indicators with operational indicators that reveal whether externally financed functions are being maintained in practice.





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The equity implications are equally important. Aid financed functions often serve populations that are politically under represented, geographically remote, displaced or affected by stigma. WHO's recent guidance on the health financing emergency explicitly emphasises the need to cushion sudden reductions in external assistance and protect vulnerable populations while adapting to reduced aid [15]. If withdrawal is managed primarily through aggregate fiscal targets, the residual risk may be shifted toward groups least able to compensate through out of pocket spending or political voice. A credible transition should therefore assess distributional consequences explicitly, including effects on rural areas, fragile settings, key populations, women and children, and patients requiring continuous treatment. In this respect, service protection is not only a technical requirement but also an equity and accountability obligation.

Finally, the interpretation of current evidence should remain appropriately cautious. Early surveys, budget reviews and country team assessments have limitations, including incomplete public documentation, differences between budgeted and executed spending, and uneven reporting across countries and programmes. However, uncertainty does not justify assuming replacement. In conditions of asymmetric risk, the burden of proof should fall on transition plans to demonstrate credible financing, procurement continuity and service protection before external support is reduced. This standard would move the debate from rhetorical claims about ownership toward observable evidence of readiness.

A transition compact with empirical conditions

The appropriate response is not an open ended defence of aid dependence. It is a transition compact that makes feasibility and accountability explicit. This approach is consistent with the





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Global Fund's sustainability, transition and co financing framework, which links transition to maintaining and scaling service coverage, increasing domestic financing, aligning with national systems and supporting strong transition planning [16,17]. Such a compact should be designed around the following conditions.

1. **A fiscal feasibility baseline.** Before a co financing target is set, publish the tax base, debt service burden, health budget share, execution rate, available fiscal measures and the value of each externally financed function.
2. **Predictable, phased financing.** Commitments should be released on a timetable aligned with national budget cycles and procurement lead times. Abrupt cliffs should trigger bridge financing or an agreed service prioritisation process.
3. **Protected essential service floors.** Specify commodities, frontline workers, diagnostics, prevention, surveillance and key population services that cannot be reduced without explicit risk assessment and public disclosure.
4. **Additionality that can be verified.** Count as co financing only resources that increase available purchasing power for the agreed functions, net of substitutions and adjusted for budget execution.
5. **Purchasing and systems integration.** Link domestic finance to procurement, provider payment, information systems and workforce transition so that funds can actually buy continuity of care.
6. **Public monitoring.** Report planned and actual releases, service readiness, stock outs, workforce losses and coverage by subnational area and population group.
7. **Independent review and adaptation.** Where fiscal or service protection milestones fail, revise the timetable rather than treating an unmet assumption as a country failure.





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Policy recommendations

Actor	Immediate action	Accountability test
Donors and global health funds	Replace abrupt funding cliffs with bridge financing, phased co financing and explicit protection of essential commodities and frontline delivery functions.	No withdrawal should proceed unless service floors, procurement continuity and verified successor financing are documented.
Ministries of finance	Publish the fiscal feasibility baseline, including debt service, revenue measures, execution rates and the realistic envelope for additional health spending.	Domestic commitments should be judged by executed additional spending, not announced allocations alone.
Ministries of health	Map externally financed functions to budget lines, procurement systems, provider contracts and workforce arrangements before assuming domestic absorption.	Continuity should be tracked through stock outs, service readiness, staffing, treatment retention and subnational coverage gaps.
Researchers and accountability bodies	Evaluate transition compacts prospectively using linked financing, procurement, workforce and service use data.	Evidence should distinguish partial mitigation from full replacement and identify which populations bear the residual risk.





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Implications for research and policy

The next research priority is a prospective, country level account of how financing losses are transmitted into health system performance. Such work should link aid commitments and disbursements with treasury releases, subnational allocations, procurement orders, stock data, workforce contracts, facility readiness and service utilisation. As exposure and timing vary across programmes, geographical areas and financing channels, quasi experimental designs may become possible. These should be complemented by political economy, budget process and implementation research that explains why a formally approved allocation did or did not become usable care at the point of service.

Research should also evaluate bilateral and multilateral transition agreements as financing interventions in their own right. The key questions are whether co financing commitments are fiscally credible, whether domestic resources are genuinely additional, which services and populations are protected, and whether risk is shifted toward poor, rural, displaced or stigmatised groups. These questions are aligned with Gavi's and the Global Fund's use of co financing and transition policies to increase domestic ownership while sustaining coverage and programme impact [16,18,19]. Mortality modelling can remain part of the evidence base, but it should not substitute for observable leading indicators that policy can still affect: prevention, case finding, treatment retention, supply continuity, workforce stability and timely payment for service delivery.





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Conclusion

The 2025–26 contraction in DAH is not a conventional transition because, in many highly exposed countries, it lacks a credible successor financier pathway. Domestic resource mobilisation remains indispensable for sustainable and nationally owned health systems, but it operates on a different time scale from abrupt aid withdrawal and is mediated by political allocation, debt obligations, budget execution and health system purchasing capacity [5,6,12]. The defensible policy position is therefore neither fatalism nor faith in automatic substitution. It is a transparent, phased and independently reviewed transition compact that protects essential services while domestic fiscal institutions, purchasing systems and accountability mechanisms are strengthened [14–17]. Donors should operationalise this compact by publishing transition impact assessments before reductions are made, financing time bound bridges where service floors are at risk, aligning disbursements with national budget and procurement cycles, protecting commodities and frontline delivery functions from abrupt cuts, and counting co financing only when domestic resources are executed and demonstrably additional. Where these conditions are not met, the responsible course is to revise the timetable rather than reclassify an unmanaged withdrawal as country ownership.

Declarations

Competing interests

The author is Director General of the Social Health Insurance Authority (SHIA), Federal Government of Somalia. This analysis is prepared in an independent academic capacity and does not necessarily represent the position of the Government of Somalia.





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