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The Retreat in Global Development Assistance and its Impact on Mortality

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For over twenty-five years, a steady international consensus, underpinned by a shared commitment to the Sustainable Development Goals, has guided the expansion of development aid in pursuit of a stronger, more egalitarian, and more sustainable global health ecosystem. That era is now behind us. We are currently witnessing a **systemic rupture** by traditional donors that can't be understood as a fiscal correction, but a fundamental pivot in international relations and spending priorities. Between 2023 and 2026, four out of the five biggest donor countries —the United States, Germany, the United Kingdom, and France— have substantially reduced their development assistance budgets.

The scale of this reversal is unprecedented. The **United States**, the country that appeared to have initiated this domino effect in early 2025 by virtually dismantling and defunding USAID,[1] has recently passed its Fiscal Year 2026 spending bill, reducing development spending by 23% in fiscal year 2026 relative to the base budget in fiscal year 2024.[2] However, the **United Kingdom** has been the one headlining the retreat in relative terms with its aid budget projected to hit 0.3% of GNI by 2027, the lowest point since the turn

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1 Debusmann Jr B. More than 80% of USAID programmes 'officially ending'. BBC News. 2025 Mar 10. Available from: https://www.bbc.com/news/articles/cdx2401vn5ro

2 Mitchell I, Hughes S. UK aid cuts now deeper than the US after Congress pushes back. Center for Global Development. 2026 Feb 15. Available from: https://www.cgdev.org/blog/uk-aid-cuts-now-deeper-us-after-congress-pushes-back

of the century,[3] culminating a tendency that started in 2020 with the dissolution of its independent development department (DFID). **Germany**, which briefly became the primary global aid provider in absolute terms following the US withdrawal in 2025, is now on a trajectory to erase a decade of progress by cutting its humanitarian and health pledges significantly. Looking beyond the cuts, **France** has effectively abandoned its innovative solidarity taxes on airlines and financial transactions, redirecting those funds into its general budget instead of the health initiatives they were designed to support.

In all of these countries, aid cuts have been framed as a question of discipline, efficiency, and competing priorities. In practice, though, they are rushed and poorly-explained decisions with direct and measurable consequences on real people. The recent wave of cuts marks a **break with a long-standing pattern of solidarity and partial burden-sharing in times of crisis**. None is graver than the one affecting global health. In too many low-and-middle income settings, live-saving programmes are already reporting interruptions in essential medicines and services, while multilateral organisations face funding gaps that translate into reduced vaccine coverage, testing, treatments, and basic care. The findings presented in this policy brief suggest that the combined retreat of major European donors alone could result in millions of additional preventable deaths by 2030 if funding levels are not restored. These figures illustrate the scale of the trade-offs involved.

1. Quantifying the Human Cost of Disinvestment

"The results depend on the severity of the retreat, but the simulated mild defunding scenario —the one most similar to the current path of defunding— could result in 9.4 million of preventable deaths up to 2030."

While the argument for international aid is a political, even an existential one, scientific evidence can also provide insights in terms of its human toll. A recent study[4] by ISGlobal's *IMPACTaid* research group offers a comprehensive evaluation of how official development assistance (ODA) saved lives across 93 low- and middle-income countries (LMICs) between 2002 and 2021.

The study finds an association between higher ODA per-capita funding and a **23% reduction in all-cause mortality**. This association is even more accentuated for children under five years of age, where higher ODA funding is linked to a **39% reduction in mortality**. Major communicable diseases responsible for an immense burden of disease worldwide, such as HIV/AIDS and malaria, also saw a reduction in mortality linked to the highest level of aid per-capita (a 70% and a 56% reduction respectively). Nutritional deficiencies also saw their mortality more than halved during this period in countries that received higher per-capita assistance. These gains were made by funding essential services, from specific programs in immunisation and maternal care to broader system improvements like water sanitation, education, and overall health systems strengthening.

3 Donor Tracker. UK / Global Health. Berlin. SEEK Development; 2025. Available from: https://donortracker.org/donor_profiles/united-kingdom/globalhealth

4 Da Silva AF, et al. Impact of two decades of humanitarian and development assistance and the projected mortality consequences of current defunding to 2030: retrospective evaluation and forecasting analysis. The Lancet Global Health. 1 Feb 2026; Available from: https://doi.org/10.1016/s2214-109x(26)00008-2

Upon evaluating the past impact, the study also aims to predict the potential fallout if current funding cuts continue through 2030. The results depend on the severity of the retreat, but the simulated mild defunding scenario —the one most similar to the current path of defunding— could result in **9.4 million of preventable deaths** up to 2030.

While these findings are statistically robust, they must be viewed with an understanding of scientific limitations. Using country-level data can help to identify broad trends, but ultimately fails to account for variations at the individual or household level. In this case, relying on ODA per capita assumes funding is equally distributed within each recipient country, which adds another layer of limitation. At the same time, observational studies cannot prove causality, only an association between variables. Beyond statistical limitations lay practical ones: the **fungibility of aid**, which occurs when a recipient government reallocates its own domestic funds away from a sector receiving ODA toward other priorities, ultimately rendering earmarked aid fungible, can limit its effectiveness. Epidemiological analyses such as this one have a limited capacity to assess this phenomenon and its effects on public expenditure and health outcomes in each implementing country.

However, even if the exact figures are heavily constrained by methodological limitations derived from the real-world complexity of the issue, this study succeeds in **identifying the broad effectiveness of the investment**. The results offer a fundamental lesson: by accepting these cuts as the "new normal," we risk losing global gains in mortality and disease prevention associated with decades of investment in development assistance, even if ODA cannot be deemed the sole driver of those gains.

2. Conclusions and Policy Recommendations

"The policy challenge is therefore twofold: to avoid further erosion of resources while advancing reforms that improve the system's resilience and legitimacy."

If we are to tackle the consequences of this process seriously, we should start by making a realistic assessment of the situation. What we are witnessing is not a temporary correction, but a systemic shock in which fewer resources are available, needs continue to grow, and institutions are forced to prioritise more aggressively. The language of efficiency —triage funding, targeting, value for money— reflects a system adapting to scarcity. But scarcity itself is not exogenous. It is the result of political choices about how public resources are allocated.

In the background, a narrative of inevitability is taking hold. We have accepted a "new normal" where governments and agencies are reorganising their strategies around the assumption of permanently constrained resources. This may appear pragmatic, but it risks **institutionalising underfunding** as a baseline.

The comparison with other areas of public spending is instructive. The resources required to sustain core global health interventions represent only a small fraction of total expenditure in donor countries. While official development assistance is projected to fall again in 2026, **defence spending across OECD countries is rising** sharply, with increases of tens of billions of dollars. This suggests that the issue is less about fiscal capacity than about prioritisation across policy domains. Underinvestment in prevention is likely to generate higher costs over time,

including in terms of crisis response, instability and health security.

These choices are highly questionable, both on economic and geopolitical grounds. By massively expanding military spending at the expense of the stabilising power of health and development, donors are not only making a bad investment (every dollar invested in conflict prevention can save up to $103 in future crisis response costs);[5] they are also creating a strategic vacuum to be filled by other global actors such as Russia and China, diminishing Western influence on the global stage. Furthermore, the degradation of health systems among implementing countries represents a fundamental health security breach that renders the global community vulnerable to cross-border health crises and emergencies.

Restoring previous funding levels is an immediate priority. This alone, however, would not be sufficient on its own. The current moment is also the result of **structural weaknesses in the aid architecture**: high dependence on a limited number of donors, fragmented financing mechanisms, and governance arrangements that do not adequately reflect the distribution of needs. The policy challenge is therefore twofold: to avoid further erosion of resources while advancing reforms that improve the system's resilience and legitimacy.

As highlighted by leading voices in global philanthropy,[6] the human cost of these decisions is both immediate and avoidable, and alternative policy options remain available. A number of **actionable proposals** have already been identified. These measures are technically feasible and, in many cases, already piloted:

- To recommit to predictable funding targets, including a gradual return to 0.7% of GNI for development cooperation.
- To protect global health allocations from diversion to domestic expenditures.
- To expand the use of innovative financing instruments —such as solidarity taxes or advanced financing mechanisms— to reduce reliance on annual budget cycles.
- To scale up debt relief and debt-for-health swaps to increase fiscal space in high-burden countries.
- To strengthen the role of multilateral development banks in providing concessional finance and supporting long-term investments in health systems.
- To promote co-financing mechanisms and domestic resource mobilisation to reinforce sustainability and national ownership.

An additional, largely ignored priority, is **improving the evidence base that informs these decisions**. Despite the scale of current changes, there are significant gaps in timely and comparable data on the impact of aid reductions on health outcomes. Indirect effects —such as supply chain disruptions or system-level weakening— remain under-measured, and existing evidence is not systematically integrated into policy processes. Addressing these challenges requires investment in monitoring systems, independent evaluation frameworks and transparent reporting standards that link financial inputs to health results. It also requires **strengthening the interface between evidence and decision-making**, ensuring that data is translated into formats that are usable for policymakers and visible to the public.

The trajectory of global health will not be defined by constraints, but by choices. Treating the current path as a "new normal" would mean accepting avoidable risks and preventable losses

5 Kraus J, Iveson M. Conflict Prevention is 100 Times Less Costly than Crisis Response. Berlin: ONE; 12 Feb 2025. Available from: https://data.one.org/analysis/conflict-prevention-less-costly

6 Statement by Dr. Rajiv J. Shah on the human cost of foreign aid cuts. The Rockefeller Foundation. 2026 Feb 2. Available from: https://www.rockefellerfoundation.org/news/statement-by-dr-rajiv-j-shah-on-the-human-cost-of-foreign-aid-cuts/

as a baseline. **The alternative is still within reach**: restoring ambition, aligning financing with needs, and recognising global health for what it is —not a residual policy, but a central pillar of collective security and economic stability.

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