Responding to the health financing emergency

Immediate measures and longer-term shifts

Conference copy

World Health Organization

Contents

Acknowledgements

This guidance paper represents a collective effort across the global health financing and economics team of the World Health Organization (WHO) to bring together and adapt evidence and best practices on health financing-related policies, actions and analytics for sustainable and equitable progress towards universal health coverage (UHC), also drawing on guidance provided in previous financial crises.

The guidance paper was developed with the leadership of Kalipso Chalkidou, Matthew Jowett and Anna Vassall from the WHO Department of Performance, Financing and Delivery. The core writing team from this department comprised Susan Sparkes, Helene Barroy and Inke Mathauer, with significant contributions from Xu Ke, Alexandra Earle, Filip Meheus, Altea Sitruk and Gabriela Flores. WHO's regional health financing focal points provided substantial inputs, including from Sarah Thompson (WHO Regional Office for Europe), Triin Habicht (WHO Regional Office for Europe), Alia Luz (WHO Regional Office for the Western Pacific), Annie Chu (WHO Regional Office for the Western Pacific), Sophie Faye (WHO Regional Office for Africa) and Jayendra Sharma (WHO Regional Office for South-East Asia). WHO gratefully acknowledges feedback from external reviewers, comprising Joseph Kutzin (independent), Kelechi Ohiri (National Health Insurance Authority of Nigeria), Agnes Couffinhal (World Bank Group) and Patrick Hoang-Vu Eozenou (World Bank Group).

WHO also acknowledges input from the March 2025 meeting "Navigating health financing cliffs: learning for a new era in global health", sponsored by the Alliance for Health Policy & Systems Research. Contributions also came through the consultation process of the 78th World Health Assembly resolution "Strengthening health financing globally".

Financial support for the development of the guidance paper and the related work programme was provided by the United Kingdom Foreign, Commonwealth & Development Office, Wellcome Trust and Deutsche Gesellschaft für Internationale Zusammenarbeit.

Edited and design by Global Communication Matters.

Abbreviations

FMIS	financial management information system
HFPM	Health Financing Progress Matrix
HTA	health technology assessment
MTEF	medium-term expenditure framework
PFM	public financial management
UHC	universal health coverage
WHO	World Health Organization

Introduction

Many countries are faced with difficult choices following the sudden, large reduction in external funding for their health systems that began in January 2025. In response to this immediate shock, countries are also rethinking their longer-term vision for financing health systems built on domestic resources. This guidance paper outlines a range of policy actions and priority analytics for policy-makers to consider, to immediately respond to the impact of external funding reductions, and to advance UHC through the longer-term development of health financing systems.

By the end of 2024, health financing systems continued to be vulnerable even years after the onset of the COVID-19 pandemic. From a macro-fiscal perspective, as countries went into COVID-19 with historically high sovereign debt, they emerged with even greater debt and higher debt servicing payments (*1*). Combined with global inflation, trade constraints and economic uncertainty, the domestic budget space for health in many low- and middle-income countries faces extreme pressures from multiple sources for the foreseeable future (*2*).

These pressures place additional stress on health financing systems many of which suffer from systemic underfunding, deprioritization of health in public budgets, underutilization of funds, continued reliance on inefficient and inequitable out-of-pocket spending and dependency on external aid. Furthermore, the health challenges that countries and their populations face are not due to subside, particularly because climate change, noncommunicable disease and mental health burdens, ageing populations, conflicts and pandemic preparedness all place ever-increasing demands on health financing systems.

These challenges were already mounting when the sudden reductions in external aid hit in early 2025. The announcement by the government of the United States of America in January 2025 to suddenly pause and then dramatically reduce foreign aid was then compounded by announcements of reductions from other donor countries (*3*). While the impact of the U.S. reductions is by far the largest, at least 10 other countries of the Organisation for Economic Co-operation and Development's Development Assistance Committee have also announced reductions in aid for health, with estimates of a more than 30% reduction in total external aid for health in 2025 as compared to 2023 (*4*). The full impact of these reductions, on both financing

and overall health and wellbeing, will become clearer over time; however, initial WHO indications from March 2025 show immediate disruptions in services in approximately 70% of 108 low- and middle-income countries surveyed (*5*). The most frequently reported impacts were on health emergency preparedness and response, public health surveillance, service provision, humanitarian aid and the health and care workforce, with concerns raised over the ability to sustain coverage for immunization, malaria, HIV, tuberculosis, sexually transmitted infections, family planning and maternal and child health services (*6*). These reductions in external financing and declining government budgets for health are likely to lead to increases in out-of-pocket payments or reduced access, increasing levels of financial hardship and forgone care, and a deterioration in the progress towards UHC that many countries have made.

The combination of shocks to both domestic and external financing flows requires urgent action and analytics in many countries, especially those that rely more heavily on external aid. The current moment requires an immediate response to mitigate the worst effects of the shock and provides an opportunity to emphasize critical shifts in health financing systems to focus on sustainable and efficient approaches that can support domestically driven health systems fit for the future. These shifts require changes to financing mechanisms and priorities at the country level, as well as regional and global levels. These changes will require engaging with complex political economy dynamics to fully operationalize (*7*).

As solutions are explored and new ideas proposed, it is critical that the evidence on what works to align health financing systems with UHC objectives remains central to policy decisions (*8*). This includes focusing on domestic public spending on health (*9*) and expanding coverage through existing "health coverage schemes". Health coverage schemes, which include funds from government health budgets, are a pool of health risks and funds that provide coverage to all or to large parts of the population. Critically, the government budget is the largest source of prepaid funds in nearly all low- and lower-middle-income countries, from which funds are channelled to various health coverage schemes such as directly budgeted government health facilities, a national health insurance agency (sometimes in combination with social insurance contributions) or specific government programmes for defined population groups (such as free care programmes for certain population groups or disease-specific programmes, like those for HIV and tuberculosis). It is through these schemes that public funds flow to providers. They also provide the basis for policies on benefit entitlements, priority setting, strategic purchasing and multiple other policy decisions that can help to mitigate the impact of the current shock and, at the same time, improve health system performance.

While increasing attention is being given to setting up new schemes (for example, social health insurance or voluntary, community-based health insurance schemes), their potential to realistically sustain

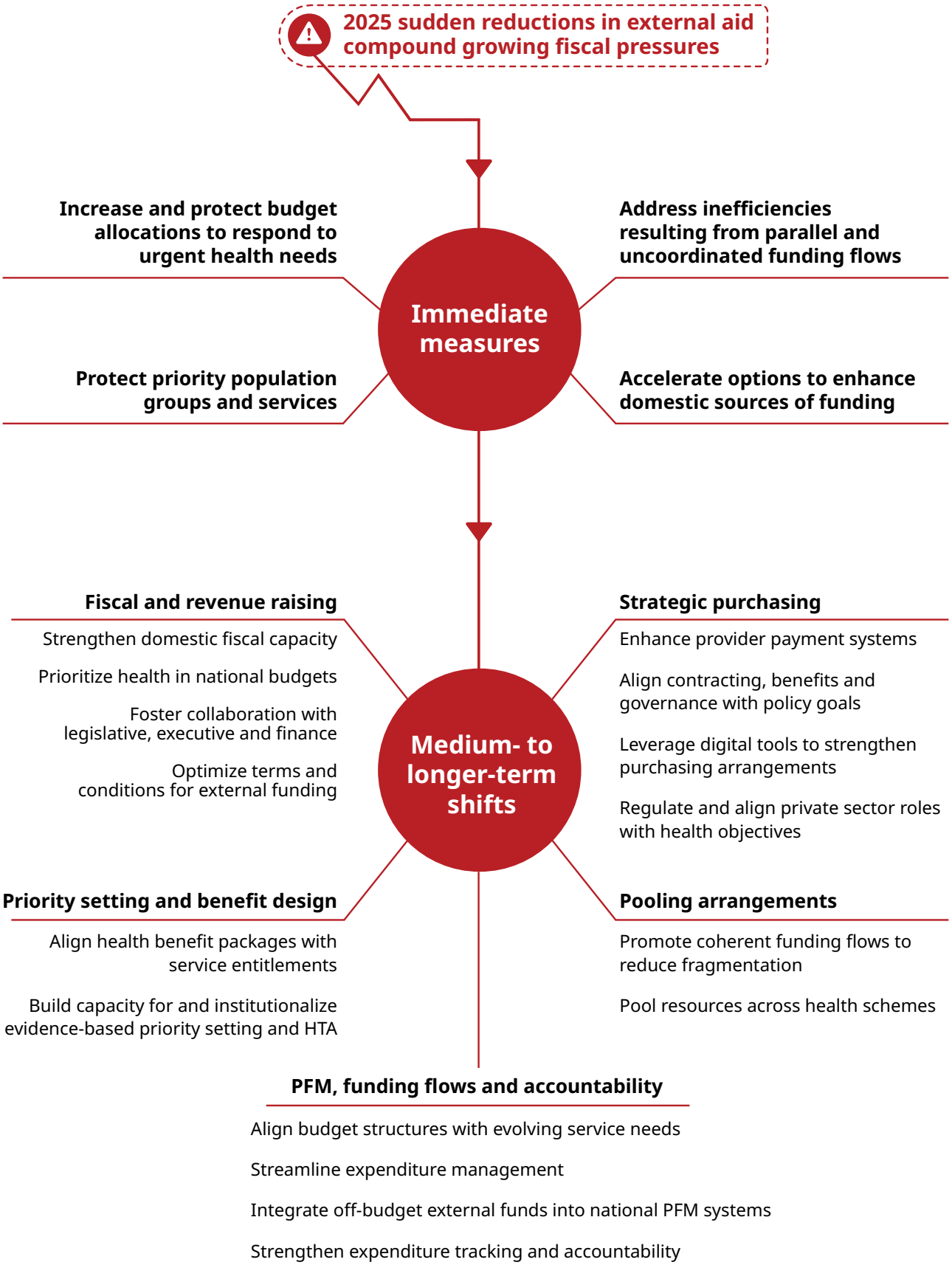
or expand coverage in both the immediate and longer-terms must be assessed. In doing so, it is essential to separate how revenues are raised from how they are channelled and pooled. For example, countries with high labour market informality are unlikely to realize much in the way of additional revenues through employment-based contributions and hence will not make significant coverage gains through these mechanisms due to fiscal, political and overall pooling constraints. While many countries are considering setting up new schemes, motivated primarily by raising new revenues, the evidence is clear that the potential for adding revenues is extremely limited when most workers are part of the large informal economy. Emphasis needs to remain on strengthening existing public revenue sources and addressing major inefficiencies, which includes building capacity for and establishing institutionalized, fair priority-setting processes to enhance long-term sustainability and feasibility. For example, in decentralized settings, where overall budget allocation decisions are made at a subnational level, more attention needs to be paid to aligning central and local priorities, improving transfer design and ensuring local budget execution capacity rather than to introducing new schemes that can add complexity to the health financing landscape.

While immediate actions are needed to minimize the negative impact of the cuts, policy responses that reorient the longer-term trajectory of domestic health financing systems should consider the key attributes of high-performing health financing systems that maximize progress towards UHC (*8*, *10*). These actions include the following:

1. equitable mobilization *and* allocation of resources to avoid increased out-of-pocket payments and enhance financial protection;
2. prioritized and cost-effective service packages and health systems investments to expand equitable coverage, which both strengthens universality and prioritizes those with the greatest health needs;
3. pooling and purchasing arrangements to support the efficient organization and delivery of integrated, high-quality services based on a primary health care approach (*11*).

Two recently adopted **World Health Assembly resolutions, "Strengthening health financing globally"** and **"Economics of *health for* all",** provide clear roadmaps and mandates for countries, funding agencies and WHO to advance in support of UHC (*12*, *13*). This guidance paper builds on these resolutions and further spells out their implications for health financing policy actions and related analytics in the current context. Figure 1 summarizes these implications.

Figure 1. Immediate health financing measures and longer term shifts



Purpose and use

This guidance paper provides a framework of health financing-related actions and analytics for countries to consider as they respond to the current emergency and set new directions for their systems to ensure sustained progress towards UHC. The primary audience is ministry of health officials engaged in health financing policy decision-making and analysis. As indicated by the icons below, certain actions require collaboration with and involvement of finance authorities and external funders.

 Finance authorities

 External funders

The measures proposed here are informed by extensive work on health financing policy, including specific evidence around donor transition *(14)* and the health financing response to severe macroeconomic crises that contribute to sustainable and equitable coverage (*15*–*17*).

This guidance paper addresses the following two questions:

- What emergency actions and rapid analytics can be realistically taken over the next 12 months to respond to the immediate impact of the health financing emergency?
- What structural shifts are needed to transition to a more sustainable, efficient and equitable health financing system in the medium to longer term, including relevant analytical areas that can be used to inform policy reform priorities?

The set of actions and analytics outlined below are not to be taken in isolation of one another nor are they all relevant in all contexts; rather they are a menu of policy options that can be prioritized and tailored to support progress towards UHC. The actions should be brought together through updated health financing strategies and plans to inform and be embedded within domestic budgeting and medium-term expenditure planning. The inherent trade-offs associated with various policy options should also be considered, for example, balancing equity and efficiency on the journey towards universalism.

Throughout many of these actions, digital technologies will facilitate, simplify or enhance various health financing tasks across revenue raising, pooling, purchasing, benefit package definition and public financial management (PFM) (*18*). More broadly, their role and use need to be guided by and specified in relevant health financing, digital health and digital public infrastructure policies to contribute to UHC progress and to avoid potential negative effects (such as digital divides, exclusion and biased outcomes, data protection and data security breaches, etc.) (*19*, *20*).

This guidance paper is structured in two interconnected sections. The first section provides the key policy actions for immediate consideration along with supporting analytics. The second section presents medium- to longer-term policy shifts and objectives, along with a select list of supportive analytics. These two sections are presented to ensure alignment between immediate actions and with medium- to longer-term policy objectives.

SECTION 1

Immediate health financing measures

(within next 12 months)

This section lays out key policy actions and related analytics to take within the next 12 months in response to the shifts in donor assistance and the need for overall health financing support.

The need to respond rapidly to the challenges outlined above can set constraints on the options available to policy-makers and practitioners. However, these constraints should not compromise medium- to longer-term objectives on the path towards UHC. The decisions made today in response to revenue reductions can create a path dependency for the future shape and form of domestic health financing architectures.

1.1 Key policy actions

> “The decisions made today in response to revenue reductions can create a path dependency for the future shape and form of domestic health financing architectures.”

Increase and protect budget allocations to respond to urgent health needs

- Reprioritize existing budget allocations towards urgent health needs by focusing spending on essential services (for example, through budgetary virements) to address immediate funding shortfalls and maintain coverage as new priorities are assessed.
- Mobilize executive leadership and parliamentarians to submit supplementary budgets, and/or where relevant, activate emergency/ contingency funding to address urgent needs (for example, procurement of essential medical supplies to prevent stockouts).
- Sustain budget transfers for health coverage schemes and explore statutory appropriations for health (for example, through legally mandated budget provisions).
- Identify where PFM adjustments are needed to align budget allocations with reprioritized services.

Protect priority population groups and services

- Maintain access to essential services without financial hardship, in particular for priority population groups, and avoid introducing new fees that can exacerbate inequities.
- Introduce policy measures to mitigate financial protection effects stemming from reduced external aid (for example, cash transfers), including, where relevant, activating contingency safety net mechanisms.

Accelerate options to enhance domestic sources of funding

- Better enforce existing tax collection mechanisms, including those for contributory payments where relevant, to minimize revenue leakage and maximize revenue collection.
- Identify potential avenues for increased tax revenue, reviewing scenarios and implementation feasibility.
- Explore opportunities for additional concessional financing, including through the strategic combination of loans from multilateral, regional and national development banks with grants from global health initiatives and other financing partners, within a sustainable financing framework (*21*).

Address inefficiencies resulting from parallel and uncoordinated funding flows

- Explore efficiency enhancements, in the context of domestic resource prioritization and informed by analytics, by integrating verticalized or parallel inputs (including salary scales) that were previously funded externally (for example, supply chains) into domestic systems where possible.
- Identify and enact financial incentives, actions and mechanisms to lower cost and price and cap expenditures, including through shifting to generics, renegotiating prices (such as those of medicines), enforcing the referral and gatekeeping systems, moving away from open-ended contracts, using more cost-effective technologies (such as, peritoneal dialysis versus haemodialysis) or aligning spending to treatment protocols that prioritize primary health care.
- Work with existing donors to ensure alignment of external funds in support of priority services, informed by rapid benefit package review and prioritization exercises.

1.2 Rapid analytics to support policy actions

The set of actions a country decides to take forward can be supported and further refined by the following analytics. Importantly, not all analytics are necessary in all contexts, and what is taken forward should be prioritized based on information needs and available resources.

Map external funding volume, channels and use as a basis for reprogramming

- Conduct a rapid mapping of external funding flows and channels, highlighting all freezes and cuts, including on- and off-budget support that delineates associated budget holders, to develop a comprehensive picture of remaining external funding.
- Evaluate costs and resource requirements for services previously externally funded to be domestically funded, including revising the scope, unit costs and prices.
- Connect donor funding flow mapping with rapid analysis of what those funds support and how they are channelled in relation to the domestic health system (through cross-programmatic efficiency analysis) (*22*) to identify opportunities for consolidation, realignment and reprogramming.[a]

Evaluate fiscal and budgetary context to align with reprioritized funding needs

- Review and evaluate overall medium-term fiscal and budgetary scenarios to understand projected government revenues, public expenditures and health spending trends, and assess the financial sustainability spending plans.

[a] An example would be to reduce duplicative information systems, procurement, surveillance and supply chains that constrain efficiency.

- Conduct rapid assessment of alignment of any existing medium-term expenditure framework (MTEF) with the annual budget allocation and re-evaluated priorities.
- Review the volume, allocation formula and channelling mechanisms of intergovernmental fiscal transfers to subnational levels, including direct transfers to service providers where relevant, to ensure efficient use of allocated resources and alignment with reprioritized health services.

Rapidly review covered services and provider payment systems and methods as a basis for aligning to new financing realities and service delivery models

- Conduct a rapid assessment of externally funded services to define a prioritized list to be maintained using domestic resources and remaining external funds, considering where and how they should be delivered.
- Assess whether any adjustments need to be made in provider payment methods and rates or alignment across payment methods, given adjustments to benefit/service delivery priorities (*23*).

Review PFM rules and processes to identify improvements that maximize budget execution and align existing budget allocations with reprioritized services and functions

- Diagnose most pressing PFM bottlenecks that impede the effective allocation, formulation and execution of health budgets in alignment with priorities and to enable consolidation across the health system (*24*, *25*).
- Engage with finance authorities to identify urgent actions required to address budget under execution in health where relevant through a systematic diagnostic approach across the budget cycle stages and stakeholders, including those from health, finance and subnational authorities (*26)*.
- Identify gaps in health expenditure tracking and explore further linkage between financial management information system (FMIS), national health accounts, resource mapping and expenditure tracking.

SECTION 2

Medium- to longer-term health financing shifts

This section lays out the key policies for sustainable health financing reform pathways to align systems to equitable coverage objectives. They are considered in five interconnected functions and domains.

1. Fiscal capacity and revenue raising
2. PFM, funding flows and accountability
3. Pooling arrangements
4. Strategic purchasing
5. Priority setting and benefit design

2.1 Key policy directions

> "As solutions are explored and new ideas proposed, it is critical that the evidence on what works to align health financing systems with UHC objectives remains central to policy decisions."

2.1.1 Fiscal capacity and revenue raising

Augment domestic fiscal capacity to ensure sustained reliance on domestic public funding for health

- Improve tax collection, administration, design and enforcement to increase compliance and tax collection, close loopholes, reduce the number of exemptions, address tax evasion and improve public sector revenue capacities overall.
- Identify potential avenues for tax revenue increases, including well designed health taxes (such as tobacco, alcohol and sugar-sweetened beverages) (*27*); revisit, update and revise tax rates and/or broaden the tax base of existing tax collection mechanisms (for example, by including all income types, like those from financial assets and rents, in contributory payments) incorporating political economy and administrative feasibility considerations (particularly around earmarking) (*28*).
- Engage in dialogue on debt restructuring and relief initiatives, including debt-for-development swaps.

Ensure budget prioritization for health within public spending

- Engage in dialogue with legislative, executive and finance leadership to sustain budget prioritization for health within the government budget, including by exploring a minimum percentage of budget allocations for health.
- Advocate for greater budget allocation to health that emphasizes the wider economic and social value of health spending together with civil society (for example, through preparation of investment cases for health).

Refine terms and conditions for external funding

- Explore new terms, conditions and options for external funding that are aligned to country priorities and systems:
  - transitional financing through short-term, targeted grants or financing sources to enhance capacities for transition;
  - blended financing options that bring together grant funding with multilateral, regional, national, development banks concessional funding.
- Work with donors to change modalities of cofinancing requirements where relevant so external sources are considered as part of an overall domestic budget envelope and are aligned with domestic PFM processes and timelines (*29*).

2.1.2 PFM, funding flows and accountability

Update budget allocation mechanisms and align budget structure to reprioritized service needs

- Accelerate the transformation of health budget structures (for example, through the sequenced introduction of budgetary programmes) or the revision of health budget structures where possible, by shifting from rigid, line-item budgeting to programme- or output-oriented budgeting, to better align budget resources with reprioritized health services (*30*).
- Consider adjustments to budget allocation formulas and/or disbursement channels at subnational levels to align with current and projected budget scenarios.[b]

Improve expenditure management processes to make health spending more agile and responsive to the needs of service providers

- Fix PFM-related bottlenecks that hinder full execution of health budget allocations, acting jointly with budget and finance authorities (*26*).
- Streamline fund disbursements across administrative levels and budget holders, including, for example, to primary care service providers through direct budgetary transfers, to fast-track spending and ensure alignment of spending to prioritized health services (*31*).

[b] This can include revisiting intergovernmental fiscal transfer targeting to prioritize the most vulnerable groups or regions, or introducing performance-linked/conditional disbursements to align disbursements with evolving priorities and funding availability.

- Align regulatory frameworks to grant primary care facilities a greater degree of financial autonomy, that is, greater discretion over how funds are allocated, utilized and accounted for, thereby enhancing responsiveness and efficiency at the service delivery level.

Support the incorporation of off-budget external funding flows into domestic PFM processes

- Work with donors towards realigning funding flows, channels and modalities, including for health workers and commodities, within domestic budgeting and spending regulatory frameworks and processes.
- Work with donors to reduce off-budget funding and provide an enabling PFM environment to accelerate the shift towards on-budget support.
- Work towards full integration of donor-funded services into domestic processes, including MTEF and strategic plan costing (including all sources of funding).
- Introduce PFM alignment indicators to monitor and report on donor funding alignment to domestic systems (in line with the Lusaka Agenda) (*32*).

Enhance expenditure tracking and accountability with the help of digital tools

- Build the capacity of the health sector to report, track and analyse health expenditure data.
- Work towards unifying health expenditure tracking and reporting into a single, integrated framework in line with FMIS to provide a comprehensive view of health spending across domestic public and external aid funding sources.
- Strengthen, and, where relevant, institutionalize health accounts using the *System of Health Accounts 2011* to produce spending data by funding source (first and foremost for domestic public sources, followed by external aid and private sources), financing arrangements, health care functions and providers, and integrate spending by disease and specific programmes or populations (*33*).
- Consolidate financial reporting in settings with multiple reporting systems and work towards gradually connecting financial and nonfinancial data systems using interoperable digital platforms, to enable near real-time, comprehensive and results-oriented accountability.

2.1.3 Pooling arrangements

Reduce fragmentation, or mitigate its consequences, through more coherent funding flows across health programmes and coverage schemes

- Identify and address inefficiencies resulting from multiple, fragmented and uncoordinated coverage schemes that create overlaps and duplications in coverage that undermine overall UHC performance.
- Integrate and ensure coherence of funding flows, including programmatic and between levels of government, through unified budgeting and planning processes, with particular emphasis on personal services-related funding (*34*).
- Harmonize funding flows to address duplications that constrain efficiency and enable integrated care, (for example, similar functions taking place in multiple programmes – labs, human resources for health, supply chains) leveraging, where relevant, interoperable and linked data systems.

Increase resource pooling among separate health coverage schemes to improve system efficiency and equitable resource distribution across different population groups and territories

- Make coverage mandatory or automatic where relevant (for example, automatic entitlement based on residence, citizenship, poverty status or for those working outside formal sector employment) so that pools become larger and more diverse.
- Promote cross-subsidization and risk-sharing across different health coverage schemes to achieve an equitable distribution of resources across territories and different population groups, in concert with other coordinated actions.[c] To implement greater cross-subsidization and risk-pooling, there are various reform options, recognizing the political sensitivities of scheme integration.
  - Start by harmonizing payment methods and rates as well as benefits across schemes as a basis for further reform.
  - Merge existing schemes to bring different population groups into a larger and more diverse pool or pools.
  - Enhance risk equalization or risk adjustment across schemes and (territorial) pools to increase redistributive capacity when merging is not possible (*35*).

[c] In particular, purchasing and supply side improvements to increase equity in access and financial protection.

BOX 1
Making health insurance work for, rather than against, UHC

The evolving context – particularly the reduction in aid to low- and middle-income countries – may prompt governments to explore new revenue sources, including employment-based contributions. However, in settings with high informality, introducing new schemes that rely on employment-based contributions is not a recommended path for coverage expansion. Given the small size of the formal workforce, this method is unlikely to generate much revenue. And, it may add substantially to the public sector's administrative costs if that responsibility for collecting contributions is given to a new agency rather than to the tax authorities or an existing social security agency. Moreover, the cost of tracking people who move in and out of coverage as they transit to or from formal to informal employment is high. International experience indicates that even where coverage is legally mandatory, large segments of the population – the "missing middle" (*36*) – usually remain uncovered, leading to greater inequalities in access to services (*37*). For countries that do not already have a social health insurance scheme, a critical assessment of these likely costs and revenue and coverage expectations should be made, before deciding to make a deep structural change like a new social health insurance scheme to health financing arrangements (*38*).

For countries that already have a social health insurance programme in place, government budget transfers into the scheme are essential to enable coverage expansion and maintenance (*39*). More specifically, for countries that already have contributory health insurance programmes, there may be opportunities to generate additional revenues and expand coverage for the most vulnerable through the following methods:

Increasing contribution rates or expanding the applicable contribution base beyond the salary component (for example, capital income or other income sources), as well as increasing ceilings for formal sector employees where applicable to increase progressive sources of revenues.[d]

Improving income assessment of workers in the informal sector and collection mechanisms for contribution to mandatory health insurance, including through digital technologies (such as mobile phone applications or automatic deduction mechanisms).

Revising copayment / user fee policies. For example, reducing or eliminating copayments for primary health care services (including treatment, medicines, medical products and diagnostic tests), especially for vulnerable households experiencing poverty. If necessary, this could be balanced by slightly higher copayments for tertiary or specialized care, in particular for higher-income

[d] Ideally, there should be no ceilings, but this may be difficult in practice for acceptability reasons.

groups. For those services for which copayments remain, they should be defined in fixed terms rather than as a percentage of charges, and where sufficient administrative capacity exists, have an annual cap on a patient's copayment liability.

Gradually increasing budget transfers from general government revenues, as fiscal capacity improves, to cover population groups who are unable to contribute or are outside the formal sector and currently excluded from coverage (*8*). [e]

In general, the key focus should be on improving equity within an existing pool (like a national scheme) rather than creating new contributory mechanisms.

In all contexts, voluntary health insurance schemes should not be used as the primary mechanism for coverage. If well regulated and with a defined role, they may serve as complementary coverage to compulsory schemes. Governments should avoid providing tax subsidies for the purchase of voluntary health insurance, and any direct subsidies should be explicitly targeted to the poor. Without such targeting, subsidies tend to disproportionately benefit higher-income populations (*40*). In contexts with a single dominant pool, policies should consider focusing on improving equity within the existing pool rather than creating new contributory mechanisms.

2.1.4 Strategic purchasing

Strengthen provider payment systems

- Consider revisions to provider payment methods, rates, and resource allocation formulas, and shift to output-based payment methods, to ensure efficient use of resources and alignment with evolving service needs, provider networks and models of care (*41*).
- Follow evidence-based guidance and good practice on provider payment reforms.
  - In the public sector, move away from rigid line-item budgets and shift to output-oriented payments (requiring data/information systems and digital technologies), in line with PFM reforms.
  - If fee-for-service payments remain, introduce a budget or volume ceiling, especially in health coverage schemes that provide access to the private sector so as to minimize the risk of supplier-induced overprovision, which can worsen financial protection for patients.

[e] Eventually, budget transfers can also serve as a general source for health coverage schemes.

- Make the connection more explicit between commodity financing mechanisms and their alignment with provider payment methods for health services that incorporate input costs to reduce inefficiencies (*42*).

Align contracting, benefit design and the governance of purchasing with policy objectives

- Strengthen and specify contracting arrangements and their enforcement (including with nongovernmental organizations) to ensure compliance with quality standards and enhance efficiency.
- Tailor and enforce referral rules (while using the potential of digital technologies to support gatekeeping and referral systems), including supportive copayment mechanisms where relevant. (*41*, *43*)
- Specify and tailor benefits design, such as deciding on generics versus branded medicines, specifying health interventions when there are alternatives and updating conditions of access (such as copayment rules, exemptions or referrals) (*44*).
- Review, and, where necessary, revise, rules and standards on provider types and levels that should best provide the defined benefit package and hence should guide contracting decisions (*41*).
- Strengthen governance arrangements for purchasing decisions and processes, as well as performance monitoring and quality oversight, to make purchasing more strategic (*45*).

Strengthen purchasing arrangements using digital technologies

- Enhance and align purchasing arrangements to the health sector's digital public infrastructure (including identity systems, payment systems, data systems) and make links across other health financing functions, PFM and the rest of the health system to strengthen coherence and synergies as well as to reduce duplications (*46*).
- Introduce digital payments for health facilities to enhance transparency and system efficiency and to support financial autonomy.
- Transition health coverage schemes with claims management processes to a digital system, thereby unlocking and leveraging more advanced purchasing functions (for example, contract monitoring, quality management and performance-based payments) that are unified and interoperable across the whole health system for all population groups.

Regulate and support alignment of the role of private sector providers and private sector capital

- Assess whether access to private sector providers should be included in publicly funded health coverage based on needs, available budgets and regulatory and purchasing capacities.
- Define, regulate and enforce the role of private sector providers that are included in publicly funded health coverage schemes within the health service delivery system and in relation to their services offered and covered, the referral rules, payment methods and rates (with safeguards against provider-induced overprovision), and quality standards.
- Regulate service provision and tariffs of private sector providers that patients use outside health coverage schemes to address the financial burden of large household out-of-pocket expenditures.
- Regulate the role and focus of private capital, including financialization of the health sector, in line with equity-oriented UHC objectives while considering that benefits from private financing may primarily relate to supporting infrastructural and other capital investments and the availability of public financing for related recurrent costs.

2.1.5 Priority setting and benefit design

Review and align the benefit package and benefit entitlement to health services

- Prioritize the benefit package and service lists (guaranteed to populations) in line with agreed criteria, considering available public financing to ensure equitable, efficient and impactful resource allocation.

Build capacity for and institutionalize evidence-informed priority setting and health technology assessment (HTA) to maintain sectoral efficiency and equity

- Establish or enhance evidence-informed, priority-setting processes across the health system to define the health benefit package that includes both cost effectiveness and budget impact criteria, including alignment with available resources, overall service standards, PHC orientation, efficiency, equity and supporting integrated models of care (*47*).
- Embed participatory governance and social participation in priority-setting processes to ensure decisions on benefit entitlements reflect the needs and preferences of populations and communities, improving legitimacy, clarity, communication, equity and responsiveness of priorities (*48*, *49*).

- Build capacity to conduct and institutionalize the use of HTA for *new* products and services for benefit package inclusion, linked with the development of related guidelines.
- Ensure that the supporting network of academic and technical teams produce and assess evidence for priority setting, employing adaptative HTA to ensure assessments are timely and policy responsive.
- Ensure that the health benefit packages are guided by strategic purchasing (including payment systems and copayments), national health planning processes, minimum service standards and delivery models, and the list of essential medicines and diagnostics (for example, product lists and pricing).

2.2 Supportive analytics and capacity-building

As with urgent actions, the above policy design must be informed by a series of systems, services, financing and economic analyses. Medium- to longer-term policy directions require data and analytics to support relevant decisions and ensure alignment with UHC objectives.

WHO's Health Financing Progress Matrix (HFPM) (*50*) offers an overarching framework to assess the performance of health financing systems. In parallel to the HFPM, WHO has also associated frameworks on priority setting and efficiency improvement, PFM, expenditure tracking and strategic purchasing. The application of each framework and tool needs to be informed by sound financial and economic analyses. In the medium- and longer-term, core domestic capacities in financial and economic analyses to support reforms must be developed and institutionalized, both within ministries of health and local supporting institutions.

The table below briefly outlines the analytical areas and the related key capacities that the policy design may require. These should not be viewed in isolation of one another, and the suite of analytics should be brought together to support and inform health financing reform, priority setting, expenditures planning and PFM. On the other hand, not all analyses may be needed at once, or resources may be insufficient to conduct them simultaneously; depending on country needs, there may be a need for prioritizing these analytical areas.

Analytical area	Scope of capacity
Expenditure tracking and analysis	Build capacity for and institutionalize the production and analysis of national health accounts to enable comprehensive monitoring of health spending and inform future health financing strategies, using digital technology and artificial intelligence where appropriate (see System of Health Accounts 2011 framework).
Evidence-informed deliberative priority setting and HTA	Assess criteria used in health benefit design and HTA, which can include cost effectiveness analysis, costing, financial protection, equity analyses, budget impact and burden of disease assessment. May additionally include health systems and scenario modelling to examine the impact and costs of different packages and health systems assessments (see WHO's updated website on WHO-CHOICE).
Fiscal analysis	Ensure the production and review of MTEFs, assessment of fiscal and budgetary scenarios, is linked with sectoral planning, costing and budgeting priorities to assess medium- to long-term financial feasibility and sustainability (see World Bank Group's Health Public Expenditure Review Guidance).
Investment appraisal and evaluation	Analyse and assess value for money, economic impact and equity of systems investments (WHO INVEST) (see WHO's Economic Evaluation and Analysis website).
PFM performance review	Identify and assess PFM bottlenecks to inform long-term system strengthening and ensure alignment with health sector needs (see WHO's PFM bottleneck assessment module in the Health Financing Progress Matrix Country Assessment Guidance and the World Bank's FinHealth: PFM in Health Tool).
Technical efficiency assessment	Conduct both (1) within-programme technical efficiency analysis and (2) cross-programmatic, system-level efficiency reviews (see WHO's Step-by-step guide to conducting cross-programmatic efficiency analysis).
Strategic purchasing	Analyse provider payment systems to ensure alignment of payment methods and rates within and across different health coverage schemes and to provide financial incentives that support service delivery goals and health outputs (see WHO's Analytical guide to assess a mixed provider payment system). Analyse governance arrangements to support strategic purchasing decisions and processes to realize efficiency, quality and transparency objectives (see WHO's Governance for strategic purchasing: An analytical framework to guide a country assessment).
Equity analyses	Use data and analyses to inform resource allocation formula to subnational levels (see WHO's Economic Evaluation and Analysis website).
Financial protection	Build capacity for and institutionalize financial protection monitoring for global and country level Sustainable Development Goal reporting. At the country level, disaggregate to subnational level to inform policy-making (see WHO's Monitoring Financial Protection website).
Effects of digital technologies on health financing functions	Assess effects (benefits and risks) of digital technologies (existing or new) used for health financing functions, particularly in relation to intermediate UHC objectives and final UHC goals (see WHO' Assessing the effects of digital technologies on health financing and UHC universal health coverage objectives guide).

Way forward

In the face of uncertainty and an ever-evolving health financing landscape, this guidance provides a set of actions and associated analytics that can be taken now to promote sustainable and equitable access to quality health services with financial protection. All of these require prioritization, careful sequencing and tailoring based on specific country needs and issues. Critically, they also form the basis of a learning and capacity-building agenda around health financing reform and policies and their complex linkages with services, people and overall health. This agenda includes documenting trade-offs that policymakers must face in how they prioritize and allocate resources from economic, political and ethical perspectives.

Global and domestic health financing is at a critical juncture where prevailing paradigms are shifting. The newly established UHC Knowledge Hub, led jointly by WHO and the World Bank, provides a clear mechanism to embed peer-to-peer learning as countries grapple with the shock of the abrupt change in the funding landscape, all while facing multiple and often competing local and global priorities.

References

Accessed on 24 October 2025

1. World economic outlook: policy pivot, rising threats. Washington, DC: International Monetary Fund; 2024 (https://www.imf.org/en/Publications/WEO/Issues/2024/10/22/worldeconomic-outlook-october-2024).

2. Kurowski C, Schmidt M, Kumar A, Mieses J, Gabani J. Peaks, declines, and mounting risks: government health spending trends through 2023. Washington, DC: Health, Nutrition and Population Global Practice of the World Bank Group; 2024 (Double Shock, Double Recovery Paper Series; https://documents1.worldbank.org/curated/en/099110524145028135/pdf/P50669217022a00d1b8dd154363fc31d6d.pdf).

3. Rasanathan K, Beltran MM, Biritwum-Nyarko AA, Blecher MS, Dybul M, Inoue H et al. Navigating health financing cliffs: a new era in global health. Lancet. 2025;405(10493):1893–5. (https:// doi.org/10.1016/S0140-6736(25)00720-2).

4. Zurn P, Barroy H, Dkhimi F, Sparkes S, Bustamante JP, Campbell J et al. Official development assistance for health: an expected 40% reduction [blog]. In: P4H Network; 23 April 2025 (https://p4h.world/en/official-development-assistance-for-health-an-expected-40-reduction/).

5. The impact of suspensions and reduction in health official development assistance on health systems: rapid WHO country office stock take: summary of results from 108 WHO country offices, 7 March–2 April 2025. Geneva: World Health Organization; 10 April 2025 (https://cdn.who.int/media/docs/default-source/integrated-health-services-(ihs)/impact-of-suspensions-and-reductions-in-health-oda-on-health-systems.pdf?sfvrsn=7b1cafcb_7&download=true). Licence: CC BY-NC-SA 3.0 I.

6. Countries are already experiencing significant health system disruptions – WHO [news release]. World Health Organization. 10 April 2025 (https://www.who.int/news/item/10-04-2025-countries-are-already-experiencing-significant-health-system-disruptions---who).

7. Political economy analysis for health financing: a 'how to' guide. Geneva: World Health Organization; 2024 (https://www.who.int/publications/i/item/9789240092099). License: CC BY-NC-SA 3.0 IGO.

8. Financing for universal health coverage: dos and don'ts. Conference edition. Geneva: World Health Organization; 2019 (Health financing guidance note, no. 9; https://p4h.world/app/uploads/2023/02/WHO19-0120health20financing20complete20low20res200922.x23411.pdf).

9. Barroy H, Vaughan K, Tapsoba Y, Dale E, Van de Maele N. Towards universal health coverage: thinking public: overview of trends in public expenditure on health (2000–2014). Geneva: World Health Organization;

2017 (https://iris.who.int/ items/6faf5f5b-83a7-4c95-ad44-578972a6dabf). License: CC BY-NC-SA 3.0 IGO.

10. Health Financing Progress Matrix: country assessment guide. Geneva: World Health Organization; 2020 (Health financing guidance, no. 9; https://www.who.int/publications/i/item/9789240017801). License: CC BY-NC-SA 3.0 IGO.

11. Rajan D, Rouleau K, Winkelmann J, Kringos D, Jakab M, Khalid F, editors. Implementing the primary health care approach: a primer. Geneva: World Health Organization; 2024 (Global report on primary health care; https://www.who.int/publications/i/item/9789240090583). License: CC BY-NC-SA 3.0 IGO.

12. Seventy-eighth World Health Assembly – daily update: 24 May 2025 [note for media]. World Health Organization. 24 May 2025 (https://www.who.int/news/item/24-05-2025-seventy-eighth-world-health-assembly---daily-update--24-may-2025#:~:text=The%20new%20Resolution%20outlines%20actions,positive%20impact%20on%20population%20health.).

13. Seventy-seventh World Health Assembly, Agenda item 15.5. 29 May 2024: Economics of health for all: Draft resolution proposed by Austria, Belgium, Brazil, Canada, Chili, China, Ecuador, Ethiopia, Finland, Hungary, Iceland, Ireland, Italy, Luxembourg, Netherlands (Kingdom of the), Slovenia and United Arab Emirates. Geneva: World Health Organization; 2024 (A77/A/ CONF./2; https://apps.who.int/gb/ebwha/pdf_files/WHA77/A77_ACONF2-en.pdf).

14. Shroff Z, Sparkes S, Paina L, Skarphedinsdottir M, Gotsadze G, Zakumumpa H et al. Managing transitions from external assistance: cross-national learning about sustaining effective coverage. Health Policy Plan. 2024;39(supplement 1):i50–i64. (https://doi.org/10.1093/heapol/czad101).

15. Thomson S, Figueras J, Evetovits T, Jowett M, Mladovsky P, Maresso A et al. Economic crisis, health systems and health in Europe: impact and implications for policy. Copenhagen: European Observatory on Health Systems and Policies and World Health Organization; 2015 (European Observatory on Health Systems and Policies Series; https://eurohealthobservatory.who.int/publications/m/economic-crisishealth-systems-and-health-in-europe-impact-and-implicationsfor-policy).

16. Sparkes S, Eozenou P, Evans D, Kurowski C, Kutzin J, Tandon A. Will the quest for UHC be derailed? Health Syst Reform. 2021;7(2). (https://doi.org/10.1080/23288604.2021.1929796).

17. Tandon A, Bloom D, Oliveira Hashiguchi L, Hoang-Vu Eozenou P, Cain J, Nigam A et al, editors. Making the case for health: a messaging guide for domestic resource mobilization. Washington, DC: Joint Learning Network for Universal Health Coverage; 2021 (https://documents1.worldbank.org/curated/en/099042223183098059/pdf/P16639805359570fe0be8b0745bc0ca76ec.pdf). License: CC BYSA 4.0.

18. Digital technologies for health financing: what are the benefits and risks for UHC? Some initial reflections. Geneva: World Health Organization; 2021 (Health financing working paper, no. 19; https://www.who.int/publications/i/item/9789240031005;). Licence: CC BY-NC-SA 3.0 IGO.

19. Assessing the effects of digital technologies on health financing and universal health coverage objectives. A guide with key questions. Geneva: World Health Organization; 2023 (https://www.who.int/publications/i/item/9789240076808). Licence: CC BY-NC-SA 3.0 IGO.

20. Mathauer I, Oranje M. Machine learning in health financing: benefits, risks and regulatory needs. Bull World Health Organ. 2024;102:216–224. (http://dx.doi.org/10.2471/BLT.23.290333).

21. Compromiso de Sevilla. New York: United Nations; 2025 (https://financing.desa.un.org/sites/default/files/ffd4-documents/2025/Compromiso%20de%20Sevilla%20for%20action%2016%20June.pdf).

22. Step-by-step guide to conducting a cross-programmatic efficiency analysis. Geneva: World Health Organization; 2022 (https://iris.who.int/server/api/core/bitstreams/08c5cc61-562f45a6-8a8e-d44bba4252d3/content). License: CC BY-NC-SA 3.0 IGO.

23. Mathauer I, Dkhimi F. Analytical guide to assess a mixed provider payment system. Department of Health Systems Governance and Financing, Geneva: World Health Organization; 2018 (WHO/UHC/HGF/Guidance/19.5; https://iris.who.int/bitstream/handle/10665/311020/9789241515337-eng.pdf). Licence: CC BY-NC-SA 3.0 IGO.

24. Public financial management. In: Health Financing Progress Matrix country assessment guide. Geneva: World Health Organization; 2020:74–83 (Health financing guidance, no. 9; https://iris.who.int/server/api/core/bitstreams/d14894db-d29b-44f2-a04e-4e59e356eee9/content). License: CC BY-NC-SA 3.0 IGO.

25. Jain M, Gurazada S. Eliminating bottlenecks in public finance to improve the delivery of health services [blog]. In: World Bank Blogs; 29 December 2023 (https://blogs.worldbank.org/en/governance/eliminating-bottlenecks-public-finance-improve-delivery-health-services).

26. Budget execution in health: from bottlenecks to solutions. Geneva: World Health Organization and International Bank for Reconstruction and Development/World Bank Group; 2025 (https://openknowledge.worldbank.org/server/api/core/bitstreams/e5af7cb7-9e83-4ba2-a89e-be7defd12755/content). Licence: CC BY-NC-SA 3.0 IGO.

27. Blecher EH, Ozer C. PFR fundamentals series: how-to note - health taxes in public finance reviews. Washington, DC: World Bank Group; 2025 (https://documents.worldbank.org/en/publication/documents-reports/documentdetail/099062325190093634/p506801-109763f9-2a10-4c37-aab8-ce0f3872e079).

28. Cashin C, Sparkes S, Bloom D. Earmarking for health: from theory to practice. Geneva: World Health Organization; 2017 (https://iris.who.int/server/api/core/bitstreams/e86ff798-c8e5-41de-816c-8cdad66e2496/content). Licence: CC BY-NC-SA 3.0 IGO.

29. Sparkes S, Yungrattanachi M, Fan V. Conditioned domestic 'co-financing' policies in global health: a landscape analysis. Washington, DC: Center for Global Development; 2024 (CGD Policy Paper, 341; https://www.cgdev.org/publication/conditioned-domestic-co-financing-policies-global-health-landscape-analysis).

30. Barroy H, Blecher M, Lakin J, editors. How to make budgets work for health. A practical guide to designing, managing and monitoring programme budgets in the health sector. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240049666). Licence: CC BY-NC-SA 3.0 IGO.

31. Direct facility financing: concept and role for UHC [policy brief]. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240043374). Licence: CC BY-NC-SA 3.0 IGO.

32. Sparkes S, Barroy H, Chalkidou K, Baker P, Witter S. Money talks: the Lusaka Agenda financing alignment indicators [website]. Center for Global Development; 09 January 2025 (http://cgdev.org/blog/money-talks-lusaka-agenda-financing-alignment-indicators).

33. Health accounts [website]. World Health Organization; (https:// www.who.int/health-topics/health-accounts#tab=tab_1).

34. Health financing and economics: cross-programmatic efficiency analysis [website]. World Health Organization (https://www.who.int/teams/health-financing-and-economics/health-financing/diagnostics/cross-programmatic-efficiency-analysis).

35. Mathauer I, Torres LV, Kutzin J, Jakab M, Hanson K. Pooling financial resources for universal health coverage: options for reform. Bull World Health Organ. 2019;98(2):132–9. (http:// dx.doi.org/10.2471/BLT.19.234153).

36. Universal health coverage study series (UNICO) [website]. World Bank Group (https://www.worldbank.org/en/topic/health/publication/universal-health-coverage-study-series).

37. Yazbeck AS, Savedoff WD, Hsiao WC, Kutzin J, Soucat A, Tandon A et al. The case against labor-tax-financed social health insurance for low- and low-middle-income countries. Health Aff (Millwood). 2020;39(5):892–7. (https://doi.org/10.1377/hlthaff.2019.00874).

38. Can people afford to pay for health care? Evidence on financial protection in 40 countries in Europe. Summary. Copenhagen: WHO Regional Office for Europe; 2023. (https://iris.who.int/server/api/core/bitstreams/c985536c-a941-4575-b819-28c80b02cfbb/content). Licence: CC BY-NC-SA 3.0 IGO.

39. Global spending on health: emerging from the pandemic. Geneva: World Health Organization; 2024 (https://www.who.int/teams/health-financing-and-economics/global-spending-on-health-2024). Licence: CC BY-NC-SA 3.0 IGO.

40. Mathauer I, Kutzin J. Voluntary health insurance: potentials and limits in moving towards UHC. Geneva: World Health Organization; 2018 (Health financing policy brief, no.5; https://iris.who.int/items/da5ced02-da32-486b-a925-35946f134373). Licence: CC BY-NC-SA 3.0 IGO.

41. Mathauer I, Dale E, Jowett M, Kutzin J. Purchasing health services for universal health coverage: how to make it more strategic? Geneva: World Health Organization; 2019 (Health financing policy brief, no. 6; https://iris.who.int/items/152f6660-9ff6-4f78-aee6-e2334b7259df). Licence: CC BY-NCSA 3.0 IGO.

42. Cashin C, Kutzin J, Hanson K, London School of Hygiene & Tropical Medicine. It's time to build a field for health commodity financing: sustainable domestic systems to ensure access to essential medicines and products [blog]. In: Results for Development; 08 July 2025 (https://r4d.org/blog/commodity-financing-sustainable-domestic-systems-ensure-access-essential-medicines-products/).

43. The Online Referral System in the state health insurance scheme of Karnataka, India: a digital tool to contribute to strategic purchasing. Geneva: World Health Organization; 2025 (Country studies series on digital technologies for health financing; https://www.who.int/publications/i/item/9789240107342). Licence: CC BY-NC-SA 3.0 IGO.

44. Benefit design: the perspective from health financing policy. Geneva: World Health Organization; 2022 (Health financing policy brief, no. 8; https://iris.who.int/server/api/core/bitstreams/cdd3c634-b30c-460f-889d-5d5b1eb3318c/content). Licence: CC BY-NC-SA 3.0 IGO.

45. Governance for strategic purchasing: an analytical framework to guide a country assessment. Geneva: World Health Organization; 2019 (Health financing guidance, no. 6; https://www.who.int/publications/i/item/governance-for-strategic-purchasing-an-analytical-framework-to-guide-a-country-assessment). Licence: CC BY-NCSA 3.0 IGO.

46. Oranje M, Mathauer I. Exploring the effects of digital technologies in health financing for universal health coverage: a synthesis of country experiences and lessons. Oxf Open Digit Health. 2024;2(1):oqae016. (https://doi.org/10.1093/oodh/oqae016).

47. WHO-CHOICE [website]. World Health Organization; 1 January 2014 (https://www.who.int/news-room/questions-and-answers/item/who-choice-frequently-asked-questions).

48. Seventy-seventh World Health Assembly, Agenda item 1.1. 1 June 2024: Social participation for universal health coverage, health and well-being.

Geneva: World Health Organization; 2024 (WHA77.2; https://apps.who.int/gb/ebwha/pdf_files/WHA77/A77_R2-en.pdf).

49. Voice, agency, empowerment - handbook on social participation for universal health coverage. Geneva: World Health Organization; 2021 (https://iris.who.int/server/api/core/bitstreams/f7980b68-6ce9-4091-b7e2-b32ebafdecea/content). Licence: CC BY-NC-SA 3.0 IGO.

50. Health financing and economics: Health Financing Progress Matrix [website]. World Health Organization (https://www.who.int/teams/health-financing-and-economics/health-financing/diagnostics/health-financing-progress-matrix).

Department of Performance, Financing and Delivery
World Health Organization
20 Avenue Appia
1211 Geneva 27
Switzerland

Email: healthfinancing@who.int
Website: http://www.who.int/health_financing