The future of health financing

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Contents

Acknowledgements

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A new future for health financing

Debates on the future financing of health and global functions for health increasingly centre on sovereignty and self-reliance, both as a long-term ambition and through near-term commitments. The corollary to this is a more focused and effective international architecture, characterised by a smaller, more strategic role for development assistance and a shift towards provision of global public goods (GPGs).

This is not merely aspirational. Numerous countries have moved to increase domestic spending: Ghana has lifted the cap on its earmarked health levy, Nigeria has increased its health budget to offset aid shortfalls, and Kenya, South Africa and Uganda have raised allocations or restructured delivery to sustain services. (1) The scale of the transition is vast, bringing real risks and necessitating a differentiated approach, most notably for fragile and conflict-affected states. But there are important signals of political will that set a precedent for the kind of choices that must be made in years to come.

The shift was, in part, catalysed by crisis. In early 2025, global health was in a state of shock. Major donors announced sudden, deep and largely simultaneous cuts. Under immense pressure, organisations cut budgets, closed programmes and restructured. The immediate conversation was consumed by what to save and what to stop. Over the following eighteen months, those decisions have given way to a wider and potentially more consequential debate about how health and global health functions will be financed in the decades ahead. The question remains unanswered, but key guiding principles are beginning to crystallise, and the processes through which change may be driven are becoming clearer. Among them are the Accra Reset and its High-Level Panel, alongside the reform deliberations and governance reviews now moving through the system, including the WHO-hosted process.

One of the most important recognitions is that the issue is not, and has never been, only about money. Beneath the data on the funding, flows, and gaps is what that money represents: the ability to set priorities, to establish the terms of cooperation, and to define what success looks like. The debate is about power, and power will not shift through efficiency gains or better coordination alone.

This policy brief sets out key considerations for the financing of health and global health functions in the decades ahead and provides some thoughts on what is needed for the future of health financing. The brief builds on a series of roundtables convened between December 2025 and March 2026 by The Partnership for International Politics and Diplomacy for Health and on the wider debate, drawing from the analyses and proposals now being advanced across the reform discourse.

Reflection to renewal: what the old system delivered, and what the new must now achieve

For over two decades international cooperation for health helped deliver important gains and contributed to saving lives across the world. Development Assistance for Health (DAH) more than tripled between 2000 and 2019.(2) It put millions on HIV treatment, helped halve child mortality, and built institutions – including Gavi and The Global Fund – that have shaped markets, created financing mechanisms, and delivered medicines and vaccines at a price and scale no single country could have achieved alone.

Yet the same architecture also entrenched the power relations of the moment it was built. Priorities too often set in donor capitals and boardrooms, and delivery systems developed not to build national capacity, but to control fiduciary risk. Ministries of health spent scarce political capital and senior talent managing aid relationships instead of building their own systems. Accountability ran upward to funders more than downward to citizens. These flaws were well known, but the incentives to sustain the system consistently outweighed those to change it. The political foundations that have sustained development aid have eroded. The challenge now is not to restore the previous model but to build a different one.(3)

Across the "Global South", the shift is driven not only by the retreat of aid but by a positive and long-building demand for greater independence, stronger domestic institutions, and health systems accountable to citizens. A growing number of governments are spending more domestic resources on health and treating it as a foundation for national development rather than a dependency to be managed. The ambition for change is now becoming domestic and political.

What is at stake is considerable. Decades of hard-won progress, from lives saved and epidemics pushed back, to treatments made affordable, must now be protected, as must the many who still sit at the margins of those gains. The future model must build on this and provide the basis for the next generation of health improvements.

Future financing in three parts

Here we set out three complementary parts for the future of health financing: domestic resources as the foundation, external assistance as a strategic and time-bound complement, and global public goods collectively financed to provide benefits for all. These three are mutually dependent. Increased domestic spending cannot materialise fully overnight, nor can it outrun debt service and constrained fiscal space, which only international action can unlock. When external financing is withdrawn, domestic resources should be ready to take their place. And no government will finance global functions on a new basis while the old logic and its governance still predominate.

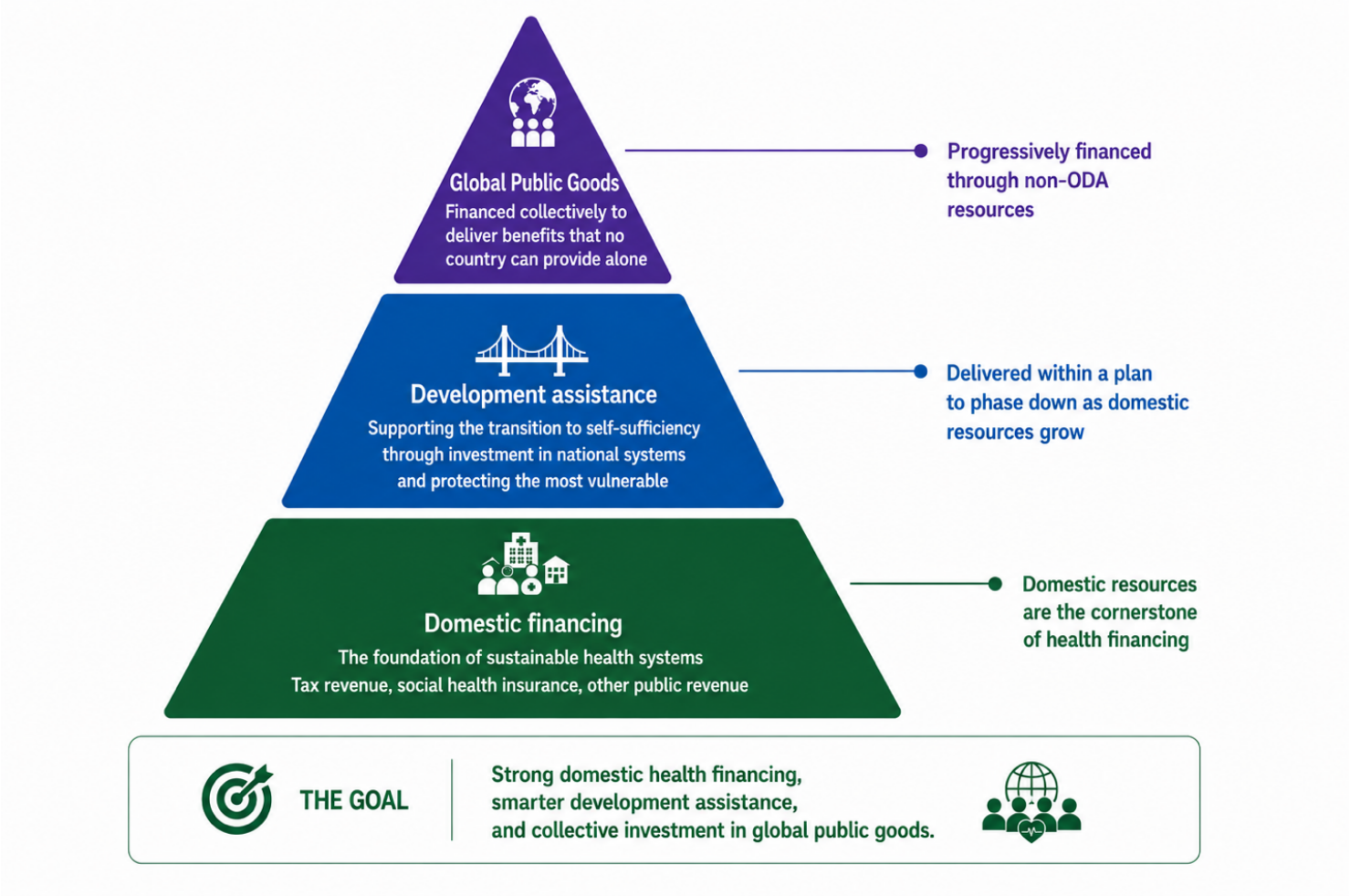

Figure 1. Three interdependent parts for the future of health financing

Domestic financing: the foundation

The next generation of health gains will be won or lost in national budgets. Demand for health sovereignty, including from heads of state and government, points to a political movement that will be central to driving the national agendas.

Change will take time, and the starting points differ widely. Government health spending per person rose steadily in both lower- and upper-middle-income countries between 2014 and 2023, but stagnated across low-income countries, ending the decade no higher than it began (Figure 2). The composition differs too: by 2023 government spending accounted for 38% of total health spending in lower-middle-income countries and 56% in upper-middle-income countries, yet out-of-pocket payments remained the single largest source in the former.(2) The patterns highlight that prior to the events of 2025 positive change was real and already under way in much of the world. They also make clear that the financing and partnerships countries need to transition towards self-sufficiency will differ significantly too.

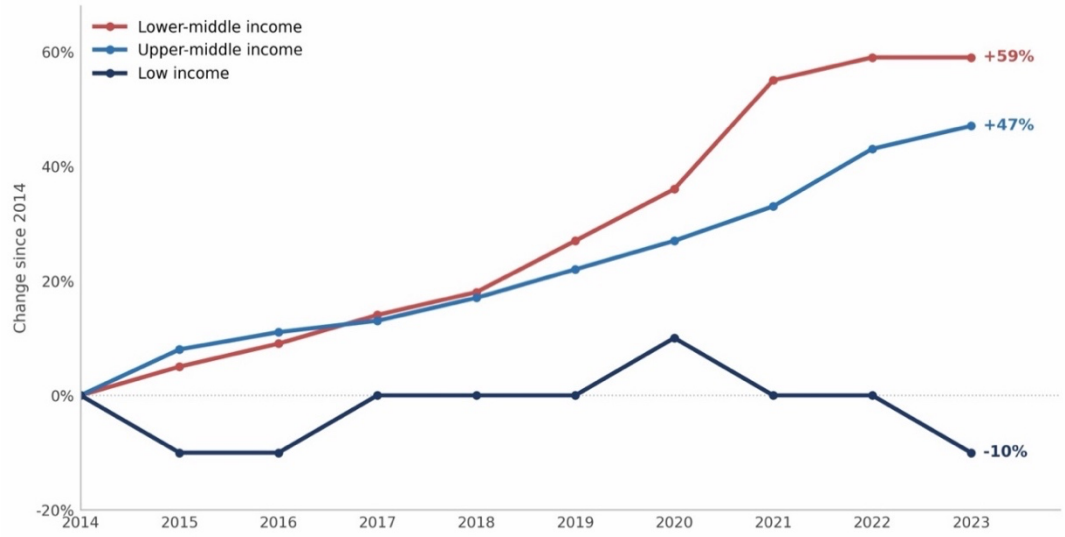

Figure 2. Change in government health spending per capita, 2014-2023 *(2)*

Domestic resource mobilisation is as much a political question as a technical one. It turns on who has the authority to raise and allocate revenue, and the constraints around those choices, including fiscal rules, tax bases, and the public trust on which taxation depends. Strengthening domestic financing is about more than raising more money. It is about building the fiscal institutions, accountability and trust through which a society decides, transparently, what it will fund and why. Domestic resources as the foundation are integral to sovereignty.

Approaches to raise domestic financing are well known and decades of knowledge and guidance exist.(4,5) What has been lacking is not knowledge but political commitment. Neither general taxation nor contributory insurance is a panacea. Poorly designed tax measures can fall hardest on the poorest, while contributory schemes, in largely informal economies, often leave them out, with enrolment skewed towards formal-sector workers. (6) Taxation for health must be a compact between government and people, who are often willing to fund systems they trust and can see working (7). In practice, most countries will need a mix, combining tax-funded coverage with pooled, prepaid and social health insurance arrangements that share risk across society (8), calibrated to local fiscal and labour-market realities. This is reflected in the differing paths of countries from Thailand, India, and Cambodia (9), to Indonesia (10) and Rwanda (11). Importantly, the pursuit of greater domestic financing must not come at the cost of shifting the burden to households through out-of-pocket payments.(6)

Health taxes, while primarily public health measures, can also raise meaningful revenue. Increasing the real price of alcohol, tobacco, and sugary beverages by 50% could generate an estimated US$3.7 trillion over five years, including US$2.1 trillion in LMICs. (12) How such taxes are designed is key, as seen with Thailand's ThaiHealth surcharge which has created a predictable revenue stream outside the budget cycle (13). This is part of a broader fiscal-reform agenda covering taxation and spending, and considerations about who controls resources and sets priorities.

Yet domestic efforts alone cannot create the necessary fiscal space. In a growing number of countries, debt service exceeds the entire government health budget (14); net flows have reversed, and the poorest countries are now, in effect, financing their creditors (15). Demanding self-reliance without considering how the international system must transform to enable this change is not a viable plan. This is where the national and international financing become inseparable: domestic spending is a national political choice, but some of the conditions that make it possible are set internationally, through action on debt restructuring, credit access and the cost of capital, or by leveraging development assistance as a focused, time-bound catalytic resource.

Development assistance for health: a transition to self-sufficiency

While DAH has fallen sharply, the volumes that remain – roughly $38 billion in 2025 and expected to stay broadly flat in the years ahead (2) – can still be impactful if used strategically. The debate is converging on what this means in practice: external assistance should be concentrated where no alternative exists, fragile and humanitarian settings, and the lowest-income countries where other sources of concessional finance are scarce. In low-income countries, external assistance still funds around 40% of all health spending, a share little changed over the past decade.

Elsewhere it should serve as a time-bound bridge for the domestic transition. In lower-middle-income countries it is already under 10% of health spending and slowly declining; and in upper-middle-income countries the amount is negligible (2).

The composition of financing to low- and middle-income countries was already changing well before 2025. Comparing two five-year periods a decade apart (2010–14 and 2020–24), new lending from private creditors collapsed by 94%, while multilateral finance rose by 124%, a shift that places multilateral development banks at the centre of the financing landscape (15) (Figure 3).

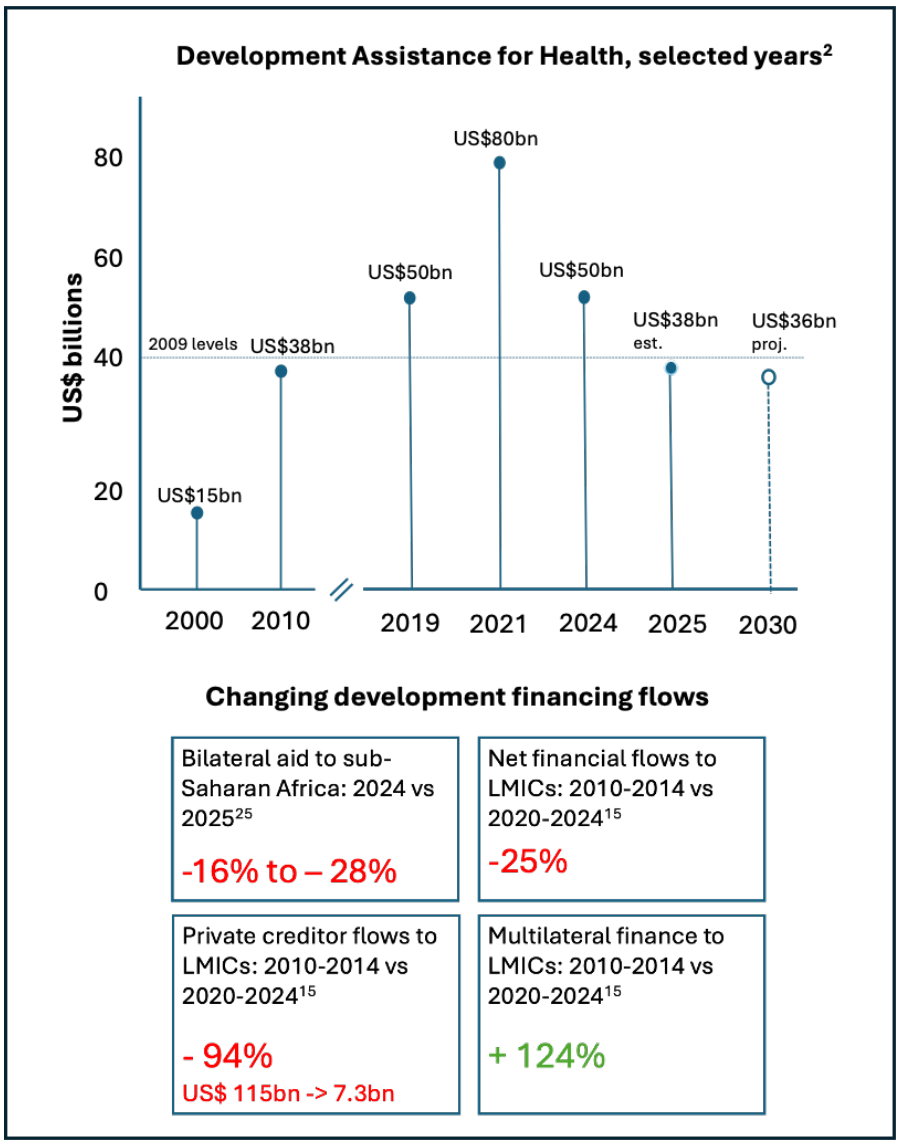

Figure 3: The changing picture of development assistance for health and development financing flows (2,15,16).

What must follow now asks something of all sides. Governments, national and sub-national, must lead; setting priorities, coordinating partners, strengthening public financial management systems and accounting to citizens for results. (17) Development partners must work in new ways: funding on-budget and through national systems, making predictable multi-year commitments, and ceding budget authority, priority-setting and visibility in exchange for building durable national capacity. (18) This must not be cover for abandoning solidarity but a means to progressively realise country ownership and sovereignty. (19) Alignment is not a one-way transfer of control; it is an exchange in which governments earn the confidence of both their citizens and their partners by showing that money aligned is money well spent. The historical weakness lies less in commitments made than in the gap between policy intent and system performance (20).

On how to do this, different proposals have been put forward. One is marginal funding, where a country finances its core package of priorities and external partners extend coverage beyond it, so that assistance is progressively crowded out as domestic capacity grows. Such a model builds in the handover rather than working towards a negotiated exit, with country-level modelling suggesting such realignment could also deliver substantially more health from existing resources. (21) Another idea is to pool fragmented donor flows into fewer, on-budget channels, such as through an IDA health window at the World Bank (22).

Fragile and conflict-affected settings bear the heaviest burden of poor health, yet are hardest to reach through national systems alone, and this will necessitate a different approach. While national strategies remain the organising point, financing will often need to flow to humanitarian actors and local civil society able to serve crisis-affected populations. Ring-fencing a share of project funding (e.g. 20%) for higher-risk and capacity-building investment is one pragmatic idea for how to build sustained national capacity in such settings. (23)

In the new landscape, the role of the multilateral development banks is growing. Largely shielded from the sharpest bilateral cuts, they account for a rising share of external health financing (2), and ongoing reforms, from balance-sheet optimisation to cheaper, longer-term lending, could expand what they are able to offer countries navigating the transition. As the banks become more central, so does the role of their shareholders, and here most power still resides with countries of the Global North. Replenishing IDA and protecting its concessionality against a drift toward harder terms or private-sector windows(24,25), and steering finance toward investments that advance universal health coverage is key. Fragmentation remains an enduring issue; here MDBs, alongside global health institutions, must find ways to harmonise and align their offerings to countries.

Global functions: shared benefits, collectively paid for

Some functions protect everyone and belong to no one: pandemic threat surveillance and surge response – as recognised by the G20 High-level Independent Panel (26) – research and development for neglected threats, market-shaping for medical countermeasures, and the normative guidance underpinning multilateral collaboration. Yet the provision of these global public goods has remained far too reliant on ODA budgets (27). But financing that is politically contingent and annually renegotiated cannot reliably sustain functions whose benefits are universal.

A mundane yet important obstacle relates to the definition. ODA is an accounting construct, and donors that have pledged a share of national income to it have little incentive to finance global functions from other budget lines while spending inside ODA is credited against the target. Until what counts is redefined, the accounting itself will keep pulling global public goods back into aid budgets. The ongoing review of the DAC's rules is one key process. (28) Past reforms of what counts — grant-equivalent measurement, discount rates, the inclusion of in-donor costs — have tended to flatter donors' headline figures more than they have served recipients. (29) The test for this round is whether it is used to sharpen quality, not simply to widen what qualifies.

The starting point is to separate what ODA accounting merges. Humanitarian response, development transition, and global public goods are entirely different, with different beneficiaries, requiring different financing logics (30). The under-provision of GPGs is a structural feature of nationally led priority-setting. National institutions exist to maximise health for their own populations and will rationally under-invest in functions whose benefits cross borders (31). That is precisely why this part of the future must be built alongside country ownership and health sovereignty, not instead of it. As priority-setting shifts to countries, guided by the principle of subsidiarity, the mechanisms that provide for shared needs must evolve and strengthen.

The elements of an alternative are known and have been demonstrated elsewhere, from research (e.g. CERN) and aviation safety (ICAO). Assessed contributions to the UN system and WHO are also a long-standing demonstration that shared functions have, to a degree, been financed based on a member’s ability to contribute, though these institutions remain far too heavily reliant on voluntary contributions.

In health it is time to move to a model where contributions are assessed on ability to pay, drawing on a base of contributors that is broader than ever before due to the economic rise of middle-income countries. It should be a model that is both fairer and more resilient. Global Public Investment is one articulation of these principles — all benefit, all contribute, all decide – and is gaining traction, (32,33) including through a new government coalition. The barriers to realising this in practice — definitional agreement, contribution formulas, governance design — are real, but not insurmountable.

Delivering change

The answers to how health and global health functions should be financed in the decades ahead are becoming clearer. Historically, many well intentioned reform efforts have started and ended on paper with the failure in how vision translates to reality. A grand bargain of the type that gave rise to today's global health institutions is unlikely to emerge today. Change now is much likelier to come through regions and coalitions moving first and shifting what the sector considers normal. These are some of the ways that change can start.

Leaders put sovereignty into practice. A collective of political leaders shows the way with clear, ambitious domestic financing trajectories and commitments, along with defined asks of external partners, and dates on the handover of externally run functions. This would send a powerful message that the political rhetoric can translate into national action. For these first movers, the international offer should be predictable multi-year alignment behind the national vision, including through novel instruments such as debt swaps.

Coalitions of the willing shift the balance. The long-standing power imbalance in the old system is best rebalanced through countries working together. A group of finance and health ministers with credible national plans — negotiating transition terms, debt treatment and procurement as a bloc — carries weight no single ministry can. The coalitions need not be large or formal; they need shared interests and a common negotiating position.

Agree the terms of the financing transition, and not only among sovereign donors. Aligning behind individual national plans is necessary but not sufficient. Donors must also converge on the model of assistance itself, because it can only function as intended if the majority align behind the same idea. This means a shared view of what focusing on fragile and humanitarian settings – recognising the large diversity of needs and challenges – and the lowest-income countries **e**ntails in practice. This also means a common understanding of what "strategic and time-bound" requires when it comes to programme design and terms of cooperation. These must be negotiated with the countries that will continue to rely on development assistance. An effort led by donors alone will not have the legitimacy to hold.

Protect and build on what works. Some of the current system's most valuable achievements are collective. These include pooled procurement and market-shaping mechanisms that aggregate demand, lower prices, and secure reliable supply of essential medicines, vaccines and diagnostics. These capabilities are hard to build and easy to lose. As financing decentralises, fragmenting this purchasing power risks driving up costs and weakening supply security. The task is not to abandon what works, but to reform and expand, retaining the economies of scale and bargaining power of collective purchasing, while giving countries and regions a greater ownership stake in how they are run.

Decide what stays global. As responsibility and power shift away from the global level, an agreement must be made about what should remain. Subsidiarity will be a key principle, guiding which global institutions, functions or programmes are either no longer needed or are better situated regionally or nationally. The task now is to agree where functions should sit and to define what is meant by a Global Public Good. The definition must be specific enough to be governable, or else "global" will continue to mean whatever global institutions currently do, and definitional arguments will continue as a reason to defer change. In parallel, agreeing how Global Public Goods are governed, is part of the same task.

Shift GPG financing beyond development assistance. The economic transformation of the past twenty years means many more countries can, and should contribute to financing global functions, with contributions scaled to capacity. But a bigger table alone is not the needed reform. If paying still confers deciding, expansion merely reproduces the old logic with more members. The moment favours ambition; as the wider development-financing landscape is rethought, health – with its clearly shared threats and proven collective institutions – can be an early adopter that shows the system what the new model looks like.

Invest in better data and systems to track financing flows. Better data on how money is raised and spent is essential, underpinning the transparency and accountability needed to guide and assess health financing. Several institutions — including WHO, OECD, IHME and ONE — work to make sense of what exists, yet the picture is less clear than it should be, and routine country-level data are patchy. Timely, accurate spending data cannot be modelled or inferred; building the systems and capacity to produce it is itself a global public good worth investing in.

Closing thought

As reform processes conclude and new institutional leadership arrives, the next eighteen to twenty-four months present a rare opportunity. Each funding decision, governance reform and institutional change has the potential to make financing for health more fit for the future.

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About us

The Partnership for International Politics and Diplomacy for Health is a collaboration between the Stockholm School of Economics and Karolinska Institutet. Our work consists of four complementary and mutually reinforcing work streams: an Executive Program for future health leaders, the Health Diplomacy Institutional Network, focused research efforts, and policy engagements.

Our policy work seeks to contribute to the international dialogue on what a reformed international ecosystem for global health could look like. We call this workstream Paradigm Shifts for Global Health - Supporting Diplomacy and Policy Pathways.

This is not a standalone initiative or process, but a means through which we engage as both originators and conveyors of ideas that could potentially assist in paving the way for a reformed international ecosystem for health.

Read more here: https://globalhealthdiplomacy.se/policy-engagements

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