

BACKGROUND

Health financing gaps are stark, and extend to PPR. In 2022, average public spending on health was around USD 9 per capita per year in low-income countries, compared with USD 300 in upper-middle-income and USD 2,700 in high-income countries. Best estimates of spending contributing to PPR are USD 2–3.5 per capita in low- and lower-middle-income countries, against USD 19 in upper-middle-income and over USD 120 in high-income countries; yet PPR absorbs a far larger share of health spending in poorer countries (around 10% in LICs and 8% in LMICs, versus 3% in upper-middle- and high-income countries).¹ Spending growth in low- and middle-income countries has been driven largely by out-of-pocket (OOP) spending and external assistance, raising concerns about both equity and sustainability.

The rapid decline of ODA poses immediate risks to health systems and global health security. Around 80% of PPR-related spending in LICs and 30% in LMICs is externally financed, mostly from ODA. Bilateral health ODA from OECD Development Assistance Committee (DAC) countries fell by 40% in 2023 from its COVID-19-driven peak, and OECD projections show a further 19–33% drop between 2023 and 2025, potentially returning health ODA to levels last seen in the mid-2000s, despite the establishment of the Pandemic Fund. This compounds structural under-investment in precisely the countries where the greatest risks to global health security are likely to arise.

Spending better, and spending more domestically, are both essential to achieve the dual goals of UHC and health security. Investments that strengthen health system capacities for both endemic and epidemic disease are clear win-wins, yet substantial evidence gaps remain on the most cost-effective pathways to realise both. Tax mobilisation potential in low- and middle-income countries may be as high as 9% of GDP, and health taxes can raise revenue while improving health outcomes. The source of funds matters: domestic public spending on health is positively associated with stronger PPR capacity, whereas reliance on OOP spending erodes access to the basic services on which effective PPR depends.

RECOMMENDATIONS

Promoting aligned and sufficient domestic funding for PPR

Renew commitment to sufficient financing for PPR, in line with the progressive realisation of UHC and health security. Where required, governments should re-examine domestic health allocations in light of reduced development assistance, to ensure service continuity and maintain the core capacities required under the International Health Regulations (2005).

Strengthen tax policy and administration, including health taxes. Reducing disincentives to formalisation, well-designed presumptive tax regimes and the digital transformation of tax administrations, supported through the Platform for Collaboration on Tax and regional cooperation, are critical opportunities. WHO's normative and technical support on health taxes, including the "3 by 35" initiative, can help countries secure both revenue and health gains.

Integrate high-quality, costed PPR action plans into National Health Strategic Plans and public financial management (PFM) systems, with a consolidated planning and budget framework, formal inter-ministerial coordination (such as joint budgeting committees and integrated public investment plans), and comprehensive financial tracking and accountability. WHO can support alignment of National Action Plans for Health Security with national health and budget planning cycles.

Strengthen country-led processes to improve the technical and allocative efficiency of PPR spending along phased investment paths to UHC, by bringing PPR investments into health technology assessment and evidence-informed priority setting that accounts for co-benefits,

¹ Note that these PPR numbers are best estimates rather than observed expenditure, reflecting limited data availability (the methodological approach is detailed in the report).

consistent with resolution WHA67.23 and WHO guidance on the design of health benefit packages.

Improving the effectiveness of external assistance for health and PPR

Align external funding flows for PPR with domestic processes, in line with the Lusaka Agenda, so that ODA for health and PPR responds to national priorities and strengthens national health systems, with WHO supporting government-led coordination of partners at country level.

Use time-limited, transitional external financing, blending grants with concessional loans, to crowd in domestic spending in line with the objectives of the 4th International Conference on Financing for Development (FfD4), while targeting grants where need is greatest and limiting the debt service burden. Further work is urgently required on the feasibility and suitability of available instruments, including their coordination with the Coordinating Financial Mechanism established under the amended IHR.

Enhance regional and global collaboration on PPR financing and economics

We recognise the need to develop standardised approaches, data and analytics to understand both PPR-contributing expenditures and costs. We recommend action to:

Improve health expenditure tracking of both domestic and external funding, and specifically on PPR, at subnational, national and global levels. This should build on existing mechanisms, including the System of Health Accounts (SHA), WHO's Global Health Expenditure Database and the OECD Creditor Reporting System (CRS), and on current efforts to better align health spending, taking advantage of the digitalisation of financial management information systems (FMIS tagging) so as not to burden countries with additional reporting requirements. This is in accordance with the Strengthening Health Financing Globally WHA [Resolution](#) which calls for WHO to *"to provide support for improvement in the quality and availability of data and in the timeliness and transparency of tracking domestic and external financing flows, trends and sustainability for health over time, including through national health accounts where appropriate, and to monitor alignment with and impact of health spending on domestic budgets and on progress towards the health-related Sustainable Development Goals, with a particular focus on primary healthcare, forgone care, out-of-pocket spending and financial protection, pandemic prevention, preparedness and response, development assistance, insurance-related contributions, and working with health and finance ministries, multilateral development banks, the Organisation for Economic Co-operation and Development, global health initiatives, nongovernmental organizations, and other stakeholders"* and is consistent with the Global Health Architecture discussions and the health sovereignty agenda put forward by Accra RESET.

Ensure evidence and cross-learning regionally and globally on the value for money of different PPR investments, informing WHO global guidance and its adaptation to local health systems, to guide investments by Ministries of Finance and Health. This could include identifying research agendas, generating evidence on best buys, developing methods that can analyse value across diseases and consider joint economic impact, and providing datasets for PPR costing. Shared learning platforms should enhance learning from best practice in improving the performance and efficiency of PPR spending across countries, building understanding of common challenges and how they have been addressed, while acknowledging context specificity.

REFERENCES

1. World Health Organization, Organisation for Economic Co-operation and Development, and World Bank. Report on Financing for Pandemic Preparedness: Ensuring Sustainable and Efficient Funding. Report prepared for the G20 Joint Finance and Health Task Force, 10 October 2025. https://www.g20.utoronto.ca/2025/G20-JFHTF_Report-on-financing-for-pandemic-preparedness-1.pdf
2. Asian Development Bank. Fitting Pandemic Solutions to Scale. Manila: Asian Development Bank, April 2026. <https://www.adb.org/publications/fitting-pandemic-solutions-scale>