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Current issues in global health economics: Financing, equity, and resilience (literature review)

Abstract. The purpose of the study was to synthesise and critically evaluate current directions in global health financing, identify the principal points of tension between efficiency and equity, and assess how the financing agenda has been reshaped by climate change and pandemic risk. The study was based on a narrative synthesis of 42 scientific sources published mainly between 2010 and 2026, comprising policy reports, systematic reviews, and empirical studies indexed in major bibliographic databases, complemented by a smaller cluster of Ukrainian-authored literature on financing reform, informal payments, and system efficiency. The literature analysis showed that roughly 4.5 billion people still lack full access to essential health services, that efficiency-oriented reforms can widen socioeconomic inequalities in privately dominated systems, and that pandemic-preparedness funding is both underfinanced and geographically concentrated, with the African region receiving about 70% of total preparedness funding despite bearing a disproportionate share of the corresponding risk. Innovative financing instruments introduced between 2002 and 2015 mobilised approximately USD 8.9 billion, a modest share of overall development assistance for health, directed mainly toward vaccines and infectious-disease programmes rather than system strengthening. Climate finance was increasingly treated as a health-financing instrument rather than a purely environmental one, while low- and lower-middle-income countries would need to allocate roughly 37% and 9% of total health spending to meet global pandemic-preparedness targets under current financing patterns. The Ukrainian literature revealed a variant of these same problems: informal payments, underfinancing relative to GDP, and a post-reform financing model still being tested for its ability to combine competition among providers with equitable access. The review concluded that the central challenge for global health economics is no longer how much money is spent on health but how financing architecture, institutional capacity, and governance arrangements are matched to the setting in which they operate

Keywords: universal health coverage; health financing; equity-efficiency trade-off; pandemic preparedness financing; climate finance; health system resilience

INTRODUCTION

The economic organisation of health systems has become one of the most consequential policy problems of the twenty-first century. Health spending has risen almost everywhere over the past decade, yet this growth in financing volumes has not been matched by a corresponding improvement in the capacity of existing financing mechanisms to allocate resources efficiently, protect households financially, guarantee equitable access, and sustain the resilience of health systems under shock. This mismatch between the scale of resources mobilised and the performance of the mechanisms that allocate them is the central economic contradiction that this review examines. The 2023 global monitoring report jointly produced by the World Health Organization & The World Bank (2023) tracks coverage and financial-protection indicators across more than 190 countries and estimates that roughly 4.5 billion people still lack full access to essential health services, while catastrophic out-of-pocket spending continues to worsen rather than recede.

Using a global cross-country regression design linking a composite Universal Health Coverage (UHC) index to the disease burden of acute illness and injury,

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K. Hajjar *et al*. (2023) found that greater coverage of essential services was strongly associated with a lower burden of disease, even though financial protection remained inadequate across most of the settings they studied; their conclusion is that expanding coverage without simultaneously strengthening risk pooling leaves the financial-protection half of the UHC objective largely unmet. The relevance of this problem was sharpened rather than created by the COVID-19 pandemic. A United Nations Executive Office of the Secretary-General (EOSG) (2020) policy brief concluded that the pandemic laid bare inadequate health systems, gaps in social protection, and structural inequalities that had existed long before 2020. That experience is one reason recent scholarship increasingly treats health expenditure less as a cost to be minimised and more as an investment in resilience, productivity, and social stability (World Health Organization & The World Bank, 2023; Dale *et al*., 2024).

At the same time, new financing pressures have emerged that were largely absent from the field a decade ago. Reviewing multilateral funds, environmental taxes, and adaptive social-protection schemes, J. Borghi *et al*. (2024) argued that climate change is a direct financing problem for health systems rather than a purely environmental one. Tracking global funding flows, H. Robertson *et al*. (2024) showed that pandemic-preparedness spending is geographically concentrated rather than allocated according to underlying epidemiological risk. Auditing national health accounts, R. Katz (2023) found, separately, that this same spending is difficult to measure through conventional accounting frameworks in the first place. And a 2026 narrative review of tax-based financing instruments in Sub-Saharan Africa by F. Mpofu & S. Chilunjika (2026) demonstrated that domestic revenue mobilisation has become a central rather than a marginal question for the field. A second, closely related current issue is the relationship between efficiency and equity in the allocation of health resources. J. Asamani *et al*. (2021) argued conceptually that these two objectives should be treated as complementary rather than conflicting, yet M. Bousmah *et al*. (2025), applying an efficiency-equity decomposition to two decades of OECD health spending panel data, find empirically that efficiency-seeking reforms can widen socioeconomic inequalities in health, particularly where private provision dominates service delivery, while also showing that reducing inequality can itself raise measured efficiency.

This tension between a conceptual claim of complementarity and empirical evidence of trade-offs runs through nearly every strand of the contemporary literature, from the financing of universal coverage to the design of pandemic-preparedness funds. The same tension is visible in the Ukrainian-authored literature that predates and parallels this global debate. Analysing hospital-payment governance during Ukraine's diagnosis-related-group reform, K. Karol *et al*. (2023) showed that formal payment rules alone did not improve resource allocation without parallel governance capacity at the facility level. E. Dale *et al*. (2024), documenting the resilience of Ukraine's primary care system through the COVID-19 pandemic and the subsequent full-scale war, argued that maintaining public financing and provider autonomy was the decisive factor that prevented system collapse under compounding shocks. M. Kuzheliev & A. Nechyporenko (2024) extended this Ukrainian literature to the financing side directly, concluding that Ukraine's health expenditure has grown in nominal terms but remains structurally exposed to global fiscal shocks because the underlying revenue base has not been diversified. Together, these Ukrainian studies confirm, at the country level, the same contradiction between financing volume and mechanism capacity identified in the global literature above.

Despite this expanding literature, three gaps remain. The UHC-financing, equity-efficiency, climate-finance, and pandemic-preparedness strands are typically reviewed separately, so the extent to which they compete for the same constrained fiscal space is rarely made explicit. Existing reviews also report qualitative conclusions about financing mechanisms without systematically comparing them against a common set of criteria – source and volume of resources, capacity to expand fiscal space, and effect on efficiency, equity, and financial protection. The Ukrainian-authored literature on financing reform, informal payments, and wartime resilience compounds this gap further: it is rarely read alongside the global literature, even though it documents the same underlying contradiction in a single, intensively studied setting. This review addresses these three gaps by bringing global UHC financing, climate- and pandemic-preparedness finance, and Ukraine-specific reform within a single comparative frame. The purpose of this article was to examine current approaches to financing health systems and to assess their effects on universal access, equity, efficiency, and system resilience. The specific objectives were: (1) to map the principal thematic clusters of the recent literature and to compare the quantitative financing indicators and financing needs reported across it; (2) to systematise the principal health-financing mechanisms identified in the review and their strategic functions; and (3) to examine how the Ukrainian-authored literature engages with these same problems under conditions of fiscal constraint and active war, and to draw out the resulting implications for the institutional transferability of financing models.

To address these objectives, the study employed a narrative review approach integrating the relevant literature within a common analytical framework. The review was based on a narrative synthesis of forty-two sources retrieved through Scopus, Web of Science, PubMed, and publisher databases (BMJ Global Health, The Lancet Global Health, Bulletin of the World Health Organization, Health Affairs Scholar, and others), supplemented by policy reports from the World Health Organization, the World Bank, the United Nations Executive Office of the Secretary-General (EOSG), and Oxfam International, and by a targeted subset of Ukrainian-authored journal articles and a doctoral thesis addressing health-financing reform, informal payments, and institutional transferability. Searches combined the terms "health financing", "universal health coverage", "equity-efficiency trade-off", "fiscal space", "climate finance AND health", "pandemic preparedness financing", and "Ukraine AND health reform", each cross-referenced with "review", "systematic", or "analysis" to prioritise synthesis-type and empirical sources over opinion pieces.

Sources were selected if they addressed health-system financing, universal health coverage, equity-efficiency trade-offs, climate or pandemic-preparedness finance,

or Ukrainian health-economy reform, and were published between 2010 and 2026, with priority given to work from the past five years. Sources were assigned to one of seven thematic clusters based on their primary object of analysis – the financing mechanism, population, or policy question each source addressed most directly – producing the classification summarised in Table 1; where a source covered more than one theme, it was assigned to the cluster corresponding to its stated primary contribution. The quantitative benchmarks and the financing mechanisms were extracted directly from the results reported in the reviewed sources and grouped by the type of indicator (coverage, cost, or financing share) and by financing instrument, respectively. Sources were synthesised narratively rather than through formal meta-analysis, consistent with the heterogeneous, largely policy-analytic and review-based nature of the underlying literature.

THEORETICAL APPROACHES TO HEALTH FINANCING AND RESOURCE ALLOCATION

Financing health systems was ultimately a question of how the mechanisms that mobilise resources, the fiscal space those mechanisms create, the way risk was pooled once resources are raised, and the rules that govern how resources were then allocated interact to shape four outcomes: efficiency, equity, financial protection, and the resilience of the system under shock. Examining these interactions involved considering three recurring issues discussed in the literature: health financing as an integrated system rather than a set of independent instruments; the relationship between economic efficiency and equity in resource allocation; and the institutional transferability of financing models across countries and systems. The conceptual starting point was A. Farlow's (2016) assessment, which organised global health economics around three questions: how to build more equitable health systems, how to manage common problems in health, and how to improve evaluation and priority setting. G. Yamey *et al*. (2019) sharpened the second of these questions into an explicit financing argument, holding that "global functions" in health are transnational by definition and that the World Health Organization occupies a unique position to provide overarching governance for their financing. A. Ruckert (2013) situated the political opening for this agenda historically, arguing that overlapping financial, environmental, and fiscal crises created a window for equity-oriented reform in global health governance after 2008.

Within this frame, health financing itself was best understood as an integrated policy stack rather than a set of independent instruments. S. Witter (2010) treated taxation-based funding, insurance schemes, user charges, costing, priority setting, payment systems, and public-private mix as components of a single connected system, and T. Ottersen *et al*. (2017) showed why these components cannot be separated in practice: where risk pooling is fragmented across multiple parallel schemes, households face high out-of-pocket costs regardless of how much aggregate revenue the system raises, a framing that recurs throughout the more recent literature on innovative financing (Atun *et al.*, 2012; Gartner, 2015) and on the transferability of financing models across institutional settings. The transferability problem was not a peripheral concern: O. Mandrik (2015) showed, using Ukraine as the principal example for Central and Eastern Europe and the former Soviet region, that health-economic evidence generated in one institutional and fiscal context frequently does not travel cleanly to another, which is one reason the same financing label – insurance, tax-based funding, blended instruments – can produce very different distributional outcomes depending on where it is applied.

The second concept – the relationship between efficiency and equity – was treated not as a fixed trade-off but as an empirical question whose answer depends on financing design. J. Asamani *et al*. (2021) framed the two objectives as complementary in principle, while M. Bousmah *et al*. (2025) showed empirically, using OECD panel data, that the relationship can run in either direction depending on the extent of private provision. These two positions are not simply contradictory; they describe different scope conditions. J. Asamani *et al*.'s (2021) complementarity claim held at the level of system design in general, whereas M. Bousmah *et al*.'s (2025) trade-off finding was conditional on how much of service delivery is privately provided. The contradiction between them supplies the first criterion this review uses to compare financing mechanisms below: not whether a mechanism raises efficiency or equity in the abstract, but under which institutional conditions – and specifically, under what degree of private provision – it delivers one, the other, or both.

A second theoretical strand concerns the instruments used to expand fiscal space for health. R. Krech *et al*. (2018) extended the integrated-system logic to private capital, arguing that incorporating health into environmental, social, and governance (ESG) investment criteria could draw mainstream financial-sector actors into global health investment. J. Michaud & J. Kates (2011) and D. Gartner (2015) took a more cautious position: innovative financing mechanisms are best understood as a supplement to, rather than a substitute for, traditional development assistance, and the mechanisms that endure over time tend to be the automatic, participatory ones that integrate resource mobilisation with pooling and allocation. A third strand critiques insurance-led approaches to universal coverage on distributional grounds. C. Averill & A. Marriott (2013) argued that premium-based health insurance schemes often exclude the poorest and most marginalised households, and that progressive taxation combined with international aid provides a more reliable route to equitable coverage. Taken together, these three concepts imply that no single financing instrument can be assessed in isolation: its contribution to fiscal space must be weighed against its effect on pooling, its distributional consequences, and the institutional setting in which it is implemented. The remainder of this review applies this three-part lens – integration, efficiency-equity balance, and transferability – to the empirical and policy literature on universal coverage, climate and pandemic financing, and Ukraine's own financing reform.

THEMATIC CLUSTERS IN HEALTH-FINANCING RESEARCH

The single most consistent "current issue" was the unfinished character of the UHC agenda. The 2023 global monitoring report estimates that approximately 4.5 billion

people still lack full access to essential health services, and that catastrophic out-of-pocket spending continues to increase rather than decline (World Health Organization & The World Bank, 2023). This is consistent with K. Hajjar *et al*. (2023), who found in a global cross-country analysis that greater coverage of essential services was strongly associated with a lower burden of disease from acute illness and injury, while financial protection remained inadequate across most of the settings studied. T. Ottersen *et al*. (2017) located the underlying mechanism in weak risk pooling: where pooling is fragmented, households face high out-of-pocket costs regardless of how much aggregate money flows into a health system. The COVID-19 pandemic, as the United Nations Executive Office of the Secretary-General (EOSG) (2020) policy brief argued, did not create these weaknesses but exposed them starkly, revealing gaps in social protection and structural inequality that had been present well before 2020. Table 1 summarises how this UHC-financing cluster relates to the six other thematic clusters identified in the literature reviewed.

Table 1. Thematic clusters identified in the reviewed literature

No.	Thematic cluster	Representative sources
1	Universal health coverage and financial protection	T. Ottersen *et al*. (2017), World Health Organization & The World Bank (2023), K. Hajjar *et al*. (2023)
2	Equity-efficiency trade-off	J. Asamani *et al*. (2021), R. Krech *et al.* (2018), M. Bousmah *et al.* (2025)
3	Climate finance as health finance	J. Borghi *et al*. (2024), S. Khanal *et al*. (2024), M. Reid & I. Katz (2025)
4	Pandemic-preparedness financing	R. Katz (2023), M. Shahid *et al.* (2024), N. Ndembi *et al*. (2024), R. Duran-Fernandez *et al*. (2024), H. Robertson *et al.* (2024)
5	Innovative financing instruments and fiscal space	R. Atun *et al*. (2012; 2017), J. Michaud & J. Kates (2011), D. Gartner (2015), F. Mpofu & S. Chilunjika (2026)
6	Institutional transferability and governance	S. Witter (2010), A. Ruckert (2013), O. Mandrik (2015), G. Yamey *et al*. (2019)
7	Ukraine-specific reform and financing	T. Stepurko *et al*. (2015), L. Deshko *et al*. (2020); K. Hrytsenko *et al*. (2021), L. Beztelesna *et al*. (2024), V. Smiianov *et al*. (2025)

Source: compiled by the author based on the reviewed literature

Reading these seven clusters together shows that they are not independent research agendas but different entry points into a single underlying problem. The UHC-financing cluster establishes that coverage expands only when pooling is strong enough to convert revenue into financial protection. The equity-efficiency cluster shows that the same revenue can be allocated in ways that either narrow or widen access gaps, depending on how private provision and pooling interact. The climate-finance and pandemic-preparedness clusters demonstrate that this allocation problem intensifies under shock, when several claims compete for the same fiscal space. The innovative-financing cluster catalogues the instruments available to expand that space in the first place. None of these clusters, taken on its own, explains financing performance by resource volume alone: each one instead traces performance back to how resources are mobilised, pooled, allocated, and administered – the institutional-capacity dimension that the transferability cluster (6) and the Ukraine-specific cluster (7) examine directly. Only clusters 2 and 4 report a direct empirical trade-off – between efficiency and equity, or between financing volume and geographic equity – while the remaining clusters largely argue for complementarity without testing it empirically.

BALANCING EQUITY AND EFFICIENCY

A second major thread was the equity-efficiency trade-off in the allocation of health resources. J. Asamani *et al*. (2021) argued that equity and efficiency should be treated as complementary policy goals rather than competing ones, since inefficient systems ultimately fail to deliver equitable access regardless of how resources are formally allocated. This optimistic reading is complicated by more recent evidence. A 2025 analysis of OECD countries found that efficiency-seeking reforms can widen socioeconomic inequalities in health, particularly in systems where private provision plays a dominant role, though the same analysis also found that reducing inequality can itself improve system efficiency (Bousmah *et al*., 2025). R. Krech *et al*. (2018) pushed the financing side of this debate further, arguing that financial-sector actors and ESG-style investment frameworks can mobilise additional resources for global health, provided that health is treated as a mainstream investment criterion rather than a residual social cost. Taken together, this literature suggests that the policy implication is not simply "spend more everywhere", but rather to design financing mechanisms that buy access, financial protection, and system performance rather than shifting risk onto households (Krech *et al*., 2018; Bousmah *et al*., 2025).

Comparing these three positions directly clarifies where they actually disagree. J. Asamani *et al*. (2021) made a conceptual claim about system design in general; M. Bousmah *et al*. (2025) tested a specific institutional condition – the share of private provision – and find that the conceptual claim holds only when private provision is limited, which means the disagreement is not about whether efficiency and equity can coexist but about which institutional settings make coexistence possible. R. Krech *et al*. (2018) addressed a different link in the causal chain: even a well-designed domestic financing mechanism still needs a revenue source, and private capital is one option for expanding that base without necessarily reproducing the private-provision effect that M. Bousmah *et al*. (2025) identified, since ESG-aligned investment can flow into public as well as private delivery channels. Read this way, the equity-efficiency literature does not describe a single trade-off but three separate design questions – the extent of private provision, the source of financing, and the strength of pooling arrangements – that jointly determine whether a given reform improves or worsens equity. This means no financing mechanism examined in this review can be judged by resource volume or efficiency gains alone:

the more decisive test is distributive – which groups capture the principal benefits, onto whom the residual financial risk is shifted, and whether access genuinely improves for socially and economically vulnerable populations, rather than efficiency gains being realised simply by pricing out the households least able to pay.

CLIMATE AND PANDEMIC-PREPAREDNESS FINANCING: COMPETING CLAIMS ON A CONSTRAINED FISCAL SPACE

Climate finance and pandemic-preparedness finance represent two increasingly important areas within global health financing, as both require additional resources to strengthen health-system resilience under growing external pressures. Although they are often discussed as separate policy agendas, both rely on the same constrained pool of domestic and international resources, which creates competition between them in fiscal terms rather than making them fully independent priorities. J. Borghi *et al*. (2024) argued that climate-finance mechanisms – multilateral climate funds, carbon and other environmental taxes, micro-levies, and adaptive social-protection schemes – can be used to generate health-sector resources and make health systems more resilient to climate-related shocks. This reframing matters because it treats adaptation finance and health finance as overlapping rather than separate budget lines, which is consistent with the broader equity case made elsewhere in the climate-and-health literature (Khanal *et al*., 2024; Reid & Katz, 2025). The distributional stakes are considerable: groups that contribute least to greenhouse-gas emissions, including women, children, and adolescents in low-resource settings, are expected to bear a disproportionate share of climate-related health harms, and B. Anton *et al*. (2024) showed that financing mechanisms specifically targeted at women's, children's, and adolescents' health remain underdeveloped relative to this exposure, which strengthens the argument for using climate-linked financing instruments to protect continuity of care and household financial protection rather than treating climate adaptation and health financing as competing claims on scarce fiscal space (Borghi *et al*., 2024).

Pandemic-preparedness financing has emerged as a distinct and rapidly growing subfield within global health economics, and it draws on the same fiscal-space logic. N. Ndembi *et al*. (2024) argued that global health security and universal health coverage will both remain out of reach unless African health systems are adequately funded for emergency resilience. R. Duran-Fernandez *et al*. (2024) screened a large body of literature on this question and found that the field remains concentrated on infrastructure and institutional systems, with comparatively little attention paid to vulnerable households or to the practical feasibility of specific financing instruments. Two measurement problems compound this gap: preparedness and response spending is not captured explicitly within conventional national health accounts, which makes the financing gap difficult to quantify with precision (Katz, 2023), and the funding that does exist has remained geographically patterned rather than strategically reallocated. H. Robertson *et al*. (2024) reported that the African region has received approximately 70% of total global preparedness funding, a concentration that does not straightforwardly track underlying epidemiological risk.

M. Shahid *et al*. (2024) converted this debate into an explicit feasibility question, modelling the financing implications of the World Bank/WHO pandemic preparedness and response (PPR) targets. Their central estimate is stark: under current financing patterns, low-income countries would need to devote approximately 37% of total health spending to PPR, and lower-middle-income countries approximately 9%, if the global targets are to be met, and they conclude that ordinary year-on-year growth in official development assistance cannot close this gap on its own. This is precisely the mechanism-level evidence for fiscal competition that the climate-finance literature describes only qualitatively: M. Yaghoubi *et al*. (2023), modelling fiscal-space expansion for financing treatment costs during biological crises, show that health systems facing simultaneous shocks exhaust conventional budget-reallocation options quickly and must rely on the same small set of instruments – reserve funds, emergency borrowing, and earmarked levies – that climate-adaptation financing also depends on. Read alongside M. Shahid *et al*. (2024), this indicates that climate adaptation and pandemic preparedness are not two separate calls on health budgets but two labels attached to overlapping fiscal instruments, so that financing one can crowd out the other unless additional, instrument-specific revenue is mobilised. Table 2 collects this and several other quantitative benchmarks from the literature reviewed, since numbers of this kind are the clearest evidence of how far current financing falls short of stated policy targets.

Table 2. Quantitative benchmarks from the reviewed literature

Indicator	Value	Source
Population lacking full access to essential health services (global)	~4.5 billion people	World Health Organization & The World Bank (2023)
Total funds mobilised via innovative financing instruments, 2002-2015	~USD 8.9 billion	R. Atun *et al*. (2017)
Share of total preparedness funding received by the African region	~70%	H. Robertson *et al*. (2024)
Health spending share required for PPR targets – low-income countries	~37% of health spending	M. Shahid *et al*. (2024)
Health spending share required for PPR targets – lower-middle-income countries	~9% of health spending	M. Shahid *et al*. (2024)
Peer-reviewed papers screened on pandemic-preparedness financing	188 screened, 60 included	R. Duran-Fernandez *et al*. (2024)

Source: compiled by the author

The benchmarks in Table 2 make the fiscal-competition argument concrete. An estimated USD 8.9 billion mobilised over thirteen years through innovative financing is small relative to the 37% and 9% of total health spending that M. Shahid *et al*. (2024) calculated low-income and lower-middle-income countries would need to devote to

pandemic preparedness alone, before any climate-adaptation costs are added. This gap between historical resource mobilisation and current financing needs is the empirical basis for treating climate and pandemic-preparedness financing as a single, shared fiscal-space problem rather than two separate policy agendas, and it is the reason the following section examines the instruments available to close that gap.

INNOVATIVE FINANCING INSTRUMENTS AND FISCAL SPACE

The older innovative-financing literature remains directly relevant because it supplies the toolkit that the newer climate- and pandemic-financing literatures continue to reuse. R. Atun *et al*. (2017) identified ten innovative financing instruments that mobilised approximately USD 8.9 billion between 2002 and 2015, a relatively modest share of overall development assistance for health, and found that most of this money was channelled to vaccine programmes and major infectious-disease initiatives rather than to broad health-system strengthening or non-communicable disease control. Their earlier work argues that the genuine innovation was not the additional revenue as such, but the creation of integrated financing mechanisms capable of mobilising, pooling, allocating, and channelling resources more effectively than fragmented project-based aid.

Domestic revenue mobilisation increasingly complements this external-financing literature. A 2026 review of innovative tax models in Sub-Saharan Africa identifies tobacco, alcohol, sugar-sweetened-beverage, environmental, digital-service, and resource-extraction taxes as plausible instruments for expanding fiscal space for health, while cautioning that weak tax administration, high informality, and unresolved equity concerns can blunt their effectiveness in practice (Mpofu & Chilunjika, 2026). Read together with the older critique of insurance-led universalism, which holds that premium-based schemes tend to exclude the poorest households and places progressive taxation and international aid at the centre of equitable coverage (Averill & Marriott, 2013), this literature points toward a common conclusion: the central financing question is shifting from "how do we raise more money for health?" to "which revenue instruments are politically feasible and administratively workable in a given setting?" (Averill & Marriott, 2013; Mpofu & Chilunjika, 2026).

Comparing the instruments discussed in this subsection against the criteria used throughout this review – source and volume of resources, capacity to expand fiscal space, and effect on efficiency, equity, and financial protection – shows why no single instrument dominates. Blended international instruments (Atun *et al*., 2012; 2017) mobilised large absolute sums but a small share of total need, and they are earmarked to specific diseases rather than general system strengthening, which limits their contribution to efficiency or equity beyond the programmes they target. Domestic "sin" and digital taxes (Mpofu & Chilunjika, 2026) can in principle be scaled to a country's own fiscal capacity and reach recurrent rather than one-off financing, but their yield is constrained by weak administration and informality, which are precisely the conditions most acute in the lower-income and transition economies that need the revenue most. Progressive general taxation (Averill & Marriott, 2013) scores best on equity and financial protection because it does not exclude informal-sector households the way premium-based insurance does, but it depends on a tax base and collection capacity that many of the same constrained settings lack. The practical implication is that fiscal-space strategies need to combine instruments with complementary weaknesses rather than search for one instrument that performs well on every criterion.

INSTITUTIONAL TRANSFERABILITY AND THE GOVERNANCE OF GLOBAL HEALTH FINANCE

A distinct strand of the literature asks whether health-economic evidence and financing models actually travel across institutional settings, rather than assuming that a model that performs well in one country can simply be imported into another. S. Witter (2010) provided a useful baseline by treating financing, taxation, insurance, user charges, payment systems, and priority setting as one connected policy stack rather than a set of independent design choices. O. Mandrik (2015) made the transferability problem explicit, using Ukraine as the principal example for Central and Eastern Europe and the former Soviet region, and argues that the evidence base underpinning many financing recommendations was generated in institutional, fiscal, and administrative contexts that differ substantially from those of transition economies. This has direct governance implications: who pools financing, who allocates it, and whose risk is protected are not merely technical questions but determine whether a given financing architecture produces equity or, as M. Bousmah *et al*. (2025) showed for OECD countries, a more efficient version of exclusion. This governance lens also explains why the same instrument – provider competition, for example, or blended international financing – can raise efficiency in one institutional setting while widening exclusion in another: the difference lies not in the instrument itself but in whether the surrounding institutions pool risk, protect the poor, and enforce accountability, which is exactly the transferability question O. Mandrik (2015) raised for Ukraine and Central and Eastern Europe.

Read across the literature, institutional transferability rests on five conditions rather than on the financing instrument itself. Administrative and tax capacity determines whether a mechanism can actually be collected and enforced at the revenue-mobilisation stage. The prevailing level of risk pooling determines whether new resources translate into financial protection or are simply absorbed by fragmented schemes. Regulatory capacity determines whether private or blended instruments are steered toward system goals rather than around them. Dedicated mechanisms to protect vulnerable groups determine whether efficiency gains are captured broadly or concentrated among households already able to pay. And system-level accountability – the ability to track where resources go and hold institutions responsible for outcomes – determines whether any of the preceding four conditions can be verified rather than assumed. Ukraine offers a direct test of this five-part framework: a transition economy with constrained administrative and tax capacity, a financing reform explicitly built around provider competition, and, since 2022, a war that

has stressed every one of these conditions simultaneously. The Ukrainian case examined in the next section shows how these institutional constraints play out in practice.

UKRAINE AS A CASE STUDY IN REFORM UNDER CONSTRAINT

The Ukrainian-authored literature is considerably smaller than the global literature reviewed above, but it engages directly with the same underlying problems of underfinancing, financial-risk protection, efficiency, and institutional reform. T. Stepurko *et al*. (2015) described informal payments in Ukrainian health care as a shadow-economy or "gray market" problem that functions as a regressive, unofficial user-charge system operating alongside formally free care. K. Hrytsenko *et al*. (2021) used efficiency-frontier and regression methods to show that financing problems in Ukraine cannot be solved without first assessing system efficiency directly, comparing Ukraine with other transition and developing economies. O. Zaliska & I. Irynchyna (2020) framed the development of Ukraine's national health economy as part of a broader process of global transformation rather than a purely domestic reform agenda.

More recent Ukrainian contributions are increasingly operational rather than conceptual. V. Harbyzuk *et al*. (2021) reported that public spending on health care over 2018-2020 lagged behind the growth of the broader economy, an early warning sign for the fiscal-space arguments. L. Deshko *et al*. (2020) framed Ukraine's reformed financing model around eight explicit principles: financial protection, universality, equity, transparency, accountability, efficiency, free choice, and competition among providers. L. Beztelesna *et al*. (2024) found empirically that the reform increased patient choice and the number of formal declarations signed with private healthcare facilities, evidence of a more competitive provider market, though this raises an open question about whether competition alone improves equitable access rather than simply reallocating existing demand. V. Smiianov *et al*. (2025) extended the discussion to wartime conditions, arguing that metropolitan health systems in Ukraine require quality optimisation grounded in economic determinants in order to avoid irrational and unjustified expenditure during a period of acute fiscal and infrastructural stress. A comparative study of foreign health-financing systems and Ukraine situates these domestic findings within a broader cross-national frame, using the experience of health systems observed between 2007 and 2016 rather than treating Ukraine as an isolated case (Kinash & Savchuk, 2019).

Two further strands of the domestic literature sharpen this picture. O. Kolotilina *et al*. (2022) traced the growth of private provision alongside the public Programme of Medical Guarantees and find that the state has so far regulated private entry only loosely, which helps explain why L. Beztelesna *et al*. (2024) observed rising competition without a corresponding policy lever to keep that competition equity-enhancing. Y. Volkova *et al*. (2024), analysing the financial statements of a sample of Ukrainian healthcare institutions, report that facility-level financial provision remains uneven across regions even after the 2018 financing reform, consistent with V. Smiianov *et al*.'s (2025) argument that wartime metropolitan systems still carry irrational and unjustified expenditure. The most recent authoritative assessment, a joint WHO/World Bank review of Ukraine's financing reform, finds that the reform has nonetheless strengthened system resilience overall, maintaining universal population coverage under the Programme of Medical Guarantees despite the economic, demographic, and epidemiological shocks of the war (World Health Organization & The World Bank, 2024). Read together with E. Dale *et al*.'s (2024) finding that continuity of public financing was the decisive factor in primary care resilience, the Ukrainian literature converges on a single conclusion: the 2018 financing architecture has proved resilient at the aggregate level, but the regional and facility-level unevenness documented by Y. Volkova *et al*. (2024) and V. Smiianov *et al*. (2025) showed that resilience at the system level has not yet translated into uniform equity at the point of care. Table 3 summarises the principal financing mechanisms discussed above and their strategic function within the broader agenda of universal coverage, equity, and resilience.

Table 3. Principal financing mechanisms

Financing mechanism	Strategic function	Illustrative sources
Progressive taxation and general revenue	Broadens risk pooling; protects households excluded by premium-based insurance	S. Witter (2010), C. Averill & A. Marriott (2013)
Innovative/blended financing instruments	Mobilises earmarked funds for vaccines and infectious-disease programmes; supplements, not replaces, traditional aid	J. Michaud & J. Kates (2011), R. Atun *et al*. (2012; 2017)
ESG-aligned private capital	Draws mainstream financial-sector actors into health investment	R. Krech *et al*. (2018)
Climate-linked financing (multilateral funds, levies, adaptive social protection)	Generates health-sector resources while building resilience to climate shocks	J. Borghi *et al*. (2024)
Pandemic-preparedness pooled funds	Finances cross-border health-security functions; requires broader governance and funding base	M. Shahid *et al*. (2024), H. Robertson *et al*. (2024)
Emergency reserve funds and earmarked levies for biological/climate crises	Provides rapid liquidity when climate and pandemic shocks coincide; directly competes with the other instruments above for the same fiscal space	M. Yaghoubi *et al*. (2023), M. Shahid *et al*. (2024)
Domestic "sin" and digital taxes	Expands fiscal space domestically; effectiveness limited by weak administration and informality	F. Mpofu & S. Chilunjika (2026)
Provider-competition reform (Ukraine)	Increases patient choice; distributional effect on equitable access remains open	L. Deshko *et al*. (2020), L. Beztelesna *et al*. (2024)

Source: compiled by the author based on the reviewed literature

Taken together, the Ukrainian evidence points to a system that has become more resilient and more competitive without yet becoming more equal. The 2018 financing reform strengthened aggregate resilience and introduced genuine competition among providers, and this competition held even through the compounding shocks of the pandemic and the full-scale war. What the reform has not resolved is the distributional layer beneath that aggregate resilience: informal payments continue to function as a parallel, regressive charge on households; financial provision remains uneven across regions and facility types; and the same institutional weaknesses – limited enforcement capacity, incomplete regulation of the growing private sector, and thin accountability at the facility level – that constrain transferability elsewhere also constrain whether Ukraine's gains in system-level resilience reach the patients and regions that need them most.

CONCLUSIONS

This review showed that global health economics has moved decisively beyond the narrow question of whether a specific intervention is cost-effective. The dominant current issue was how to finance universal health coverage without transferring financial risk onto households; this is compounded by the need to balance equity against efficiency, to build the fiscal space required for climate adaptation and pandemic preparedness, and to design financing institutions capable of pooling, allocating, and channelling resources effectively across highly heterogeneous settings. In economic terms, the evidence assembled in this review pointed to a structural mismatch between the volume of resources currently mobilised for health and the growth of an increasingly correlated set of demands – universal coverage, climate adaptation, and pandemic preparedness – competing for the same constrained fiscal space; closing this gap requires not proportionally more of the same financing instruments but a deliberate reallocation toward instruments that expand the underlying tax and contribution base, rather than reshuffle a fixed pool of resources among competing priorities. The quantitative evidence reviewed here – approximately 4.5 billion people lacking full access to essential services, roughly USD 8.9 billion mobilised through innovative financing instruments between 2002 and 2015, and an estimated 37% and 9% of total health spending required from low-income and lower-middle-income countries respectively to meet global pandemic-preparedness targets – indicated that the financing gap in global health is substantial and cannot be closed through incremental growth in traditional development assistance alone.

The Ukrainian-authored literature added a domestic dimension to this global pattern. It showed that underfinancing relative to GDP, informal payments functioning as a regressive parallel user-charge system, and a post-2018 reform model built around competition among providers coexist with an explicit policy commitment to universality, equity, and financial protection. This combination makes Ukraine a useful case for testing, at the country level, the same general proposition that emerges from the global literature: the central challenge is not simply how much money flows into a health system, but whether the financing architecture, provider incentives, and institutional capacity are matched to the setting in which they are meant to operate. Future research should prioritise two directions: household-level evidence on the distributional effects of climate-linked and pandemic-preparedness financing instruments, and comparative assessment of whether Ukraine's provider-competition reform improves equitable access or mainly reallocates existing demand.

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REFERENCES

[1] Anton, B., Cuevas, S., Hanson, M., Bhutta, Z.A., Langlois, E.V., Iaia, D.G., Gasparri, G., & Borghi, J. (2024). Opportunities and challenges for financing women's, children's and adolescents' health in the context of climate change. *BMJ Global Health*, 9(4), article number e014596. doi: 10.1136/bmjgh-2023-014596.

[2] Asamani, J.A., Alugsi, S.A., Ismaila, H., & Nabyonga-Orem, J. (2021). Balancing equity and efficiency in the allocation of health resources – where is the middle ground? *Healthcare*, 9(10), article number 1257. doi: 10.3390/healthcare9101257.

[3] Atun, R., Knaul, F.M., Akachi, Y., & Frenk, J. (2012). Innovative financing for health: What is truly innovative? *The Lancet*, 380(9858), 2044-2049. doi: 10.1016/S0140-6736(12)61460-3.

[4] Atun, R., Silva, S., & Knaul, F.M. (2017). Innovative financing instruments for global health 2002-15: A systematic analysis. *The Lancet Global Health*, 5(7), e720-e726. doi: 10.1016/S2214-109X(17)30198-5.

[5] Averill, C., & Marriott, A. (2013). *Universal health coverage: Why health insurance schemes are leaving the poor behind*. Oxford: Oxfam International.

[6] Beztelesna, L., Marzec, P., Pliashko, O., Vovk, V., Khomych, S., Kucher, L., & Kucher, A. (2024). Behavioural determinants of the healthcare providers in Ukraine: Focus on competition context. *Cleaner and Responsible Consumption*, 13, article number 100192. doi: 10.1016/j.clrc.2024.100192.

[7] Borghi, J., Cuevas Garcia-Dorado, S., Anton, B., Gerardo, D., Gasparri, G., Hanson, M., Soucat, A., Bustreo, F., & Langlois, E.V. (2024). Climate finance opportunities for health and health systems. *Bulletin of the World Health Organization*, 102, 330-335. doi: 10.2471/BLT.23.290785.

[8] Bousmah, M., Abu-Zaineh, M., Combes, S., & Ventelou, B. (2025). Is the quest for efficiency harmful to health equity? An examination of the health efficiency-equity nexus in OECD countries over the past two decades. *Social Science & Medicine*, 383, article number 118379. doi: 10.1016/j.socscimed.2025.118379.

[9] Dale, E., Novak, J., Dmytriiev, D., Demeshko, O., & Habicht, J. (2024). Resilience of primary health care in Ukraine: Challenges of the pandemic and war. *Health Systems & Reform*, 10(1), article number 2352885. doi: 10.1080/23288604.2024.2352885.
[10] Deshko, L., Kostenko, Y., Koval, I., Mikhailina, T., & Oliinyk, O. (2020). The right to health: Ukraine's international obligations and financial activity of public authorities in the context of reforming the national healthcare system. *Georgian Medical News*, 304-305, 172-178.
[11] Duran-Fernandez, R., Bernal-Serrano, D., Garcia-Huitron, J.A., & Hutubessy, R. (2024). Financing for pandemic preparedness and response measures: A systematic scoping review. *Bulletin of the World Health Organization*, 102, 314-322. doi: 10.2471/BLT.23.290207.
[12] Farlow, A.W.K. (2016). The economics of global health: An assessment. *Oxford Review of Economic Policy*, 32(1), 1-20. doi: 10.1093/oxrep/grw002.
[13] Gartner, D. (2015). Innovative financing and sustainable development: Lessons from global health. *Washington International Law Journal*, 24(3), 495-515.
[14] Hajjar, K., Lillo, L., Martinez, D.A., Hermosilla, M., & Risko, N. (2023). Association between universal health coverage and the disease burden of acute illness and injury at the global level. *BMC Public Health*, 23, article number 735. doi: 10.1186/s12889-023-15671-2.
[15] Harbyzuk, V., Rudnichenko, M., & Olinkevich, S. (2021). Population health as one of the society of socio-economic of state development: Analysis of the situation and trends of financing. *Herald of Khmelnytskyi National University. Economic Sciences*, 298(5), 50-55. doi: 10.31891/2307-5740-2021-298-5(2)-8.
[16] Hrytsenko, K., Hrytsenko, A., & Mogilina, A. (2021). Assessing efficiency of health care system functioning. *Economic Analysis*, 31(4), 5-18. doi: 10.35774/econa2021.04.005.
[17] Karol, K., Hryshchuk, S., Kalanj, K., & Parii, V. (2023). The importance of good governance in hospital payment reform – a case study from Ukraine. *Health Policy OPEN*, 4, article number 100089. doi: 10.1016/j.hpopen.2023.100089.
[18] Katz, R. (2023). Challenges of tracking funding for pandemic preparedness and response. *The Lancet Global Health*, 11(3), e310-e311. doi: 10.1016/S2214-109X(23)00017-7.
[19] Khanal, S., Bolte, G., & Boeckmann, M. (2024). Sector silos in climate action – a missed opportunity to prioritize health equity. *PLOS Climate*, 3(2), article number e0000349. doi: 10.1371/journal.pclm.0000349.
[20] Kinash, I., & Savchuk, L. (2019). Comparative analysis of economic provision of health care of foreign countries and Ukraine. *Journal of Eastern European and Central Asian Research*, 6(2), 319-330. doi: 10.15549/jeecar.v6i2.286.
[21] Kolotilina, O., Lomko, V., & Prasol, L. (2022). State policy for the private healthcare sector development of Ukraine. *Health Economics and Management Review*, 3(1), 96-105. doi: 10.21272/hem.2022.1-10.
[22] Krech, R., Kickbusch, I., Franz, C., & Wells, N. (2018). Banking for health: The role of financial sector actors in investing in global health. *BMJ Global Health*, 3(1), article number e000597. doi: 10.1136/bmjgh-2017-000597.
[23] Kuzheliev, M., & Nechyporenko, A. (2024). Financing of healthcare in the context of global challenges: The Ukrainian experience. *European Scientific Journal of Economic and Financial Innovations*, 1(13), 85-94. doi: 10.32750/2024-0109.
[24] Mandrik, O. (2015). *Is transferability an issue?: Use of health economics studies in Ukraine and other Central and Eastern European countries*. (Doctoral thesis, Erasmus University Rotterdam, Rotterdam, Netherlands).
[25] Michaud, J., & Kates, J. (2011). *Innovative financing mechanisms for global health: Overview & considerations for U.S. government participation*. Menlo Park: The Henry J. Kaiser Family Foundation.
[26] Mpofu, F., & Chilunjika, S.R.T. (2026). Rethinking health financing: An analysis of innovative tax models in Sub-Saharan African contexts. *Economies*, 14(5), article number 153. doi: 10.3390/economies14050153.
[27] Ndembi, N., *et al*. (2024). Financing pandemic prevention, preparedness and response: Lessons learned and perspectives for future. *Globalization and Health*, 20, article number 65. doi: 10.1186/s12992-024-01066-4.
[28] Ottersen, T., Evans, D.B., Mossialos, E., & Røttingen, J.-A. (2017). Global health financing towards 2030 and beyond. *Health Economics, Policy and Law*, 12(2), 105-111. doi: 10.1017/S1744133116000372.
[29] Reid, M.J.A., & Katz, I.T. (2025). Redefining global health in the 21st century: Towards a more equitable global health agenda. *Global Public Health*, 20(1), article number 2464060. doi: 10.1080/17441692.2025.2464060.
[30] Robertson, H., Graeden, E., Kerr, J., Van Maele, M., & Katz, R. (2024). Follow the money: A global analysis of funding dynamics for global health security. *Health Affairs Scholar*, 2(6), article number qxae083. doi: 10.1093/haschl/qxae083.
[31] Ruckert, A. (2013). Global health governance after the financial crisis: Making health equity matter. *Canadian Foreign Policy Journal*, 19(3), 340-353. doi: 10.1080/11926422.2013.844187.
[32] Shahid, M., Schäferhoff, M., Brown, G., & Yamey, G. (2024). How feasible is it to mobilize $31 billion a year for pandemic preparedness and response? An economic growth modelling analysis. *Globalization and Health*, 20, article number 54. doi: 10.1186/s12992-024-01058-4.
[33] Smiianov, V., Korniichuk, O., Khomenko, I., Tsarenko, A., Ivakhno, O., Yasenok, V., & Smiianova, O. (2025). Economic determinants in healthcare quality optimization in Ukrainian metropolises. *Wiadomości Lekarskie Medical Advances*, 78(9), 1899-1908. doi: 10.36740/WLek/212533.
[34] Stepurko, T., Pavlova, M., Gryga, I., Murauskiene, L., & Groot, W. (2015). Informal payments for health care services: The case of Lithuania, Poland and Ukraine. *Journal of Eurasian Studies*, 6(1), 46-58. doi: 10.1016/j.euras.2014.11.002.
[35] United Nations Executive Office of the Secretary-General (EOSG). (2020). *COVID-19 and universal health coverage (UN Executive Office of the Secretary-General Policy Brief)*. New York: United Nations Executive Office of the Secretary-General (EOSG). doi: 10.18356/55119988-en.

[36] Volkova, Y., Diachenko, O., Novikova, N., & Khmurova, V. (2024). Analysis of modern approaches to financial support of healthcare facilities in Ukraine. *Financial and Credit Activity Problems of Theory and Practice*, 5(58), 150-162. doi: 10.55643/fcaptp.5.58.2024.4496.
[37] Witter, S. (2010). Understanding and using health economics and financing. In J. Walley & J. Wright (Eds.), *Public health: An action guide to improving health* (2nd ed.; pp. 87-114). Oxford: Oxford Academic. doi: 10.1093/acprof:oso/9780199238934.003.07.
[38] World Health Organization, & The World Bank. (2023). *Tracking universal health coverage: 2023 global monitoring report*. Washington: World Health Organization; International Bank for Reconstruction and Development; The World Bank. doi: 10.1596/40348.
[39] World Health Organization, & The World Bank. (2024). *Health financing in Ukraine: Reform, resilience and recovery*. Copenhagen: WHO Regional Office for Europe.
[40] Yaghoubi, M., Vahedi Idehlo, M., Mehdizadeh, P., & Meskarpour Amiri, M. (2023). Providing a model for financing the treatment costs during biological crises using the fiscal space development approach. *Health Economics Review*, 13, article number 41. doi: 10.1186/s13561-023-00450-x.
[41] Yamey, G., Jamison, D., Hanssen, O., & Soucat, A. (2019). Financing global common goods for health: When the world is a country. *Health Systems & Reform*, 5(4), 334-349. doi: 10.1080/23288604.2019.1663118.
[42] Zaliska, O., & Irynchyna, I. (2020). Development of the national model of the health economy along global transformation. *Collection of Scientific Papers "Scientific Notes"*, 21, 82-94. doi: 10.33111/vz_kneu.21.20.01.08.054.060.

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Актуальні проблеми глобальної економіки охорони здоров'я: фінансування, справедливість та стійкість (огляд літератури)

Анотація. Метою цього дослідження було узагальнити та критично оцінити сучасні напрямки фінансування охорони здоров'я у світі, визначити основні точки протиріччя між ефективністю та справедливістю, а також проаналізувати, як кліматичні зміни та ризик пандемій вплинули на переорієнтацію політики фінансування. Дослідження ґрунтувалося на наративному узагальненні 42 наукових джерел, опублікованих переважно в період з 2010 по 2026 роки, серед яких – аналітичні звіти, систематичні огляди та емпіричні дослідження, індексовані в провідних бібліографічних базах даних, а також кілька українських праць, присвячених реформі фінансування, неформальним платежам та ефективності системи. Аналіз літератури показав, що приблизно 4,5 мільярда людей досі не мають повного доступу до базових медичних послуг, що реформи, орієнтовані на ефективність, можуть поглибити соціально-економічну нерівність у системах, де домінує приватний сектор, а також що фінансування заходів з підготовки до пандемій є недостатнім і географічно незбалансованим: на Африку припадає близько 70 % загального обсягу фінансування заходів з підготовки, незважаючи на те, що цей регіон несе непропорційно велику частку відповідного ризику. Інноваційні інструменти фінансування, запроваджені у період з 2002 по 2015 рік, дозволили залучити приблизно 8,9 млрд доларів США – це незначна частка загальної допомоги на розвиток у сфері охорони здоров'я, яка спрямовувалася переважно на програми вакцинації та боротьби з інфекційними захворюваннями, а не на зміцнення системи. Фінансування заходів у сфері зміни клімату дедалі частіше розглядається як інструмент фінансування охорони здоров'я, а не суто екологічний інструмент, тоді як країнам з низьким та нижчим середнім рівнем доходу доведеться виділяти приблизно 37 % та 9 % від загальних витрат на охорону здоров'я, щоб досягти глобальних цілей щодо готовності до пандемій за нинішніх моделей фінансування. Українські публікації висвітлюють схожі проблеми: неформальні платежі, недостатнє фінансування відносно ВВП, а також модель фінансування після реформи, яка все ще проходить випробування на здатність поєднувати конкуренцію між постачальниками послуг із рівним доступом. У підсумку, головним викликом для економіки глобального здоров'я є вже не витрати на охорону здоров'я, а те, наскільки архітектура фінансування, інституційна спроможність та механізми управління відповідають умовам, у яких вони функціонують

Ключові слова: загальне медичне охоплення; фінансування охорони здоров'я; компроміс справедливість-ефективність; фінансування пандемічної готовності; кліматичне фінансування; стійкість медичної системи