

Advancing health financing for stronger financial protection in the Eastern Mediterranean Region: pathways to equity and resilience

Executive summary

Health financing is a cornerstone of resilient health systems and a critical enabler of equity in service coverage and financial protection towards advancing universal health coverage (UHC). Despite major investments and financing reforms in many countries of the WHO Eastern Mediterranean Region, financial hardship due to out-of-pocket health spending remains unacceptably high and progress towards UHC has been slow and uneven. Significant disparities persist within and among countries, particularly affecting vulnerable populations, people living in fragile and conflict-affected situations and those in countries under economic sanctions. At the same time, the rising burden of noncommunicable diseases, population ageing, large-scale displacement, rapid technological change, the effects of climate change, sustained reductions in official development assistance and global economic uncertainty are placing additional strains on health financing systems.

This technical paper reaffirms the commitment of the WHO Regional Office for the Eastern Mediterranean to regional and global resolutions on UHC and provides evidence-informed policy directions to strengthen financial protection across the diverse country contexts in the Region. It draws on recent data and country experiences to identify key structural issues, including insufficient public funding for health, fragmented pooling arrangements, passive purchasing and provider payment methods, underinvestment in primary health care, and misalignment between health financing and overall social protection systems.

To address these challenges, the paper proposes a framework for action to improve financial protection in the Region, with priority actions under four strategic directions:

- strengthening public financing for health;
- advancing equity in financial protection;
- improving efficiency and value for money in health spending; and
- enhancing health financing governance and institutional capacity for effective implementation.

While fiscal capacity, institutional maturity and levels of stability vary across countries in the Region, all countries share common strategic directions towards advancing health financing systems and strengthening financial protection, which can be framed around three mutually reinforcing objectives: investing in foundations, building/strengthening institutions and driving transformations. These objectives represent a continuum from establishing system readiness for health financing reform to achieving effective implementation and sustainable impact. However, countries may differ in their starting points.

In general, *high-income countries* are more likely to prioritize driving transformations to enhance efficiency, value for money and equity. *Middle-income countries* may focus on building/strengthening institutions to address fragmentation, improve pooling arrangements and reduce out-of-pocket spending. *Low-income countries* often need to prioritize investing in the foundations of sustainable health financing systems, including core governance and information system functions. In *fragile and conflict-affected situations*, priorities may focus on stabilizing financing arrangements to maintain continuity of essential services, while laying the groundwork for longer-term recovery and reform. However, this categorization is not prescriptive, and countries may face challenges that cut across all three objectives. Country priorities should be informed

by a comprehensive assessment of the health financing system, including its progress and maturity, and by the overall context of reform.

Across all contexts, Member States will lead health financing reforms and stakeholder engagement. WHO will provide technical and normative guidance, while enabling learning and coordination, in addition to facilitating national and inclusive policy dialogues on health financing reform for UHC and health security. Development partners will contribute catalytic financing and investments to support the expansion and sustainability of country-led reforms aligned with national priorities.

Introduction

1. Health financing is a cornerstone of resilient and equitable health systems that enable progress towards universal health coverage (UHC), health security and other health-related Sustainable Development Goals (SDGs). Well-functioning health financing systems contribute to progress on both SDG indicators for UHC: service coverage (SDG indicator 3.8.1) and financial protection (SDG indicator 3.8.2).

2. As a core dimension and goal of UHC, financial protection in health refers to the absence of financial barriers to accessing needed care and lack of financial hardship due to OOP spending (1). Financial protection advances equity by reducing the disproportionate financial burden of health care on poor and vulnerable populations, enabling access to needed services based on health needs rather than ability to pay. Conversely, by shielding individuals and households from financial hardships associated with health care, financial protection enhances their capacity to withstand and recover from shocks such as economic crises, conflicts, pandemics, displacement or disasters. Equitable health financing systems are essential for ensuring that financial protection benefits are distributed fairly across the population. At the same time, resilient health financing systems that rely on pooled and prepaid resources are better able to sustain service delivery during crises while minimizing financial hardship for households.

3. The WHO Eastern Mediterranean Region encompasses highly diverse economies and health systems. It includes six high-income countries with strong fiscal capacity and advanced health infrastructure; three upper-middle-income and eight lower-middle-income countries/territories with mixed financing systems and rising service demands; and five low-income countries with fragmented, underfunded health systems that rely heavily on external aid.¹ Among the low- and middle-income countries/territories, 10 are classified as fragile and conflict-affected situations or are operating under economic sanctions (2,3). These wide variations in economic prosperity and stability, as well as in health system capacity, create a complex landscape for health financing reforms in the Region.²

4. Furthermore, the growing burden of noncommunicable diseases, population ageing, large-scale population displacement, rapid technological change and the effects of climate change are placing increasing demands on health systems, requiring sustainable financing approaches. These challenges are further compounded by sustained reductions in official development assistance and a global economic downturn. At the same time, many countries are navigating the transition from Global Health Initiative support and other forms of external assistance, which increases pressure to mobilize domestic resources and sustain priority health programmes and services. As a result, many countries in the Region are facing persistent fiscal pressures and increasingly high levels of out-of-pocket (OOP) health spending³ that are undermining financial protection⁴, stalling the expansion of service coverage and impacting progress towards the health-related SDGs.

5. According to *Tracking universal health coverage: 2025 global monitoring report* (WHO/World Bank Group), progress towards UHC in the Region remains slow and uneven (1). Impoverishing OOP health spending is rising, with growing numbers of people forced to pay for health services at the expense of essential

¹ Low-income group: Afghanistan, Somalia, Sudan, Syrian Arab Republic and Yemen; lower-middle-income group: Djibouti, Egypt, Jordan, Lebanon, Morocco, Pakistan, Palestine and Tunisia; upper-middle-income group: Iran (Islamic Republic of), Iraq and Libya; high-income group: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates.

² Fragile and conflict-affected situations: Afghanistan, Iraq, Lebanon, Libya, Palestine, Somalia, Sudan, the Syrian Arab Republic and Yemen, as classified by the World Bank. In addition, the Islamic Republic of Iran is under economic sanctions.

³ OOP health spending is voluntary, paid at point of care without risk pooling. It is what people pay directly from their own income, savings or loans when using health services or buying health products, excluding anything covered by payment schemes such as insurance or taxes or what is being reimbursed. It includes costs such as medicines, doctor visits, hospital care and diagnostics. Cross-country measures of OOP spending exclude costs associated with accessing health services, such as transportation. Where available, these costs should be analysed as part of the assessment of barriers to service utilization.

⁴ Financial protection in health refers to both the absence of financial barriers to accessing needed care and the avoidance of financial hardship resulting from OOP health spending. SDG indicator 3.8.2, in both its original and revised formulations, measures the latter dimension, namely financial hardship due to OOP health spending. Financial barriers to access, on the other hand, influence the level and equity of service coverage that can be achieved and are therefore more closely reflected in SDG indicator 3.8.1.

needs such as food, housing and education. These trends expose deep structural vulnerabilities in health system financing and highlight widening inequities within and among countries, particularly in fragile and conflict-affected situations and in contexts affected by economic sanctions.

6. This paper builds on previous commitments such as: the Salalah Declaration on Universal Health Coverage (2018); Regional Committee resolutions EM/RC57/R.7 on strategic directions to improve health care financing in the Eastern Mediterranean Region: moving towards universal coverage 2011–2015 and EM/RC69/R.2 on building health systems resilience to advance universal health coverage and ensure health security in the Eastern Mediterranean Region (2022); World Health Assembly resolution WHA78.12 on strengthening health financing globally (2025); the Strategic operational plan for the Eastern Mediterranean Region 2025–2028; and WHO's Fourteenth General Programme of Work (2025–2030) (4–9). It provides evidence-informed policy directions to support and accelerate health financing recovery, reform and transformation across the Region.

Regional situation

Financial protection: high financial hardship, deep inequities

7. The trend in financial protection across the Eastern Mediterranean Region is concerning. An increasing share of the population is experiencing impoverishment when paying out of pocket for health at the expense of meeting their basic needs. Annex 1 presents the UHC service coverage index (SCI) and financial hardship⁵ and its components across the countries and territories of the Region.

8. In 2022, an estimated 28% of the population in the Region experienced *financial hardship due to OOP health spending*, higher than the global average (26%) (1). This indicates that, compared with the global average, a higher percentage of individuals in the Region would forgo essential needs such as food, housing and education, or would substantially reduce the consumption of other goods and services, when paying out of pocket for health care. This represents a slight improvement in the Region from 2015 (29%), but one driven primarily by a reduction in *large but non-impoverishing OOP spending*,⁶ which declined from 6.4% of the population in 2015 to 5.4% in 2022, compared with the global change from 5.2% to 5.6% (1).

9. However, the Region shows no improvement in *impoverishing OOP spending*,⁷ which increased slightly from 22.2% of the population in 2015 to 22.7% in 2022, indicating that more people in the Region are being pushed into poverty or further impoverished when paying out of pocket for health (1). In contrast, the global average for impoverishing OOP spending declined over the same period, from 22.8% of the population to 20.4% (1).

10. It is worth noting that both measures of financial hardship – large but not impoverishing health spending, and impoverishing health spending – are conditional on paying out of pocket for health care. As a result,

⁵ Financial hardship (revised SDG indicator 3.8.2) is based on a “discretionary budget approach” and is defined as the proportion of the population with positive OOP household expenditure on health exceeding 40% of “household discretionary budget”. Discretionary budget is the total consumption expenditure or net income of the cost of basic needs. People living in poverty have negative discretionary budgets, as their level of consumption expenditure or net income is already below that required to meet basic needs. This indicator can be disaggregated into the proportion of the population with “impoverishing OOP health spending” and “large but non-impoverishing OOP health spending”. The “original” SDG 3.8.2 indicator, i.e. catastrophic OOP health spending, was based on a “budget share approach” and was defined as the proportion of the population with OOP health spending exceeding 10% and 25% of “household total budget” not “household discretionary budget”.

⁶ Large but non-impoverishing OOP health spending does not impact ability to meet basic needs but substantially reduces people's ability to consume other goods and services. Under the revised SDG 3.8.2 indicator, this refers to the share of the population whose OOP health spending exceeds 40% but remains below 100% of their discretionary budget.

⁷ Impoverishing OOP health spending reduces people's ability to meet basic needs. Therefore, it classifies any spending by people who cannot afford basic needs as a source of financial hardship. It can be divided into two mutually exclusive groups of those “further impoverished by OOP health spending” and those “pushed into poverty”. Under the revised SDG 3.8.2 indicator, impoverishing OOP health spending is OOP health spending that exceeds 100% of discretionary budget or spending that leaves people with no discretionary budget once OOP is subtracted from their total budget.

individuals who forgo care because they cannot afford it (that is, those with unmet need) are not captured by these indicators and therefore by definition will not be recorded as experiencing financial hardship.

11. Sharp disparities across country income groups in the Region underscore structural vulnerabilities. Financial hardship is, on average, highest in low-income countries (31%), followed by lower-middle-income (26%) and upper-middle-income countries (25%). Impoverishing OOP spending follows a similar gradient on average (23%, 18% and 18%, respectively), showing that people living in poorer countries are more exposed to financial burden (see Annex 1).⁸

12. Inequities become even more pronounced when the data are disaggregated *within* countries. The most striking inequality is by consumption quintile, where people with the lowest levels of consumption face higher financial hardship due to OOP health spending, with averages of 60% in low-income countries, 72% in lower-middle-income countries and 48% in upper-middle-income countries. These average rates are 5–18 times higher than those faced by the population with the highest levels of consumption. Other dimensions of inequity are also evident; for example, financial hardship due to OOP health spending is, on average, consistently higher among rural populations (see Annex 2).

13. Further disparities are evident when examining household composition. People living in multigenerational households and those with children consistently show the highest average rates of financial hardship, particularly in low-income countries where the mean proportion of the population facing financial hardship reaches about 34% among those in multigenerational households and 31% in those with children, compared with 9% among adult-only households. Although these gaps narrow in middle-income settings, they still persist (see Annex 2).

Service coverage: slow and uneven progress

14. Progress towards the service coverage dimension of UHC remains slow and uneven in the Region. Between 2015 and 2023, the regional SCI⁹ increased only marginally, from 61 to 63. This remains well below the global average of 71 and far from the projected global value of 74 by 2030 (1).

15. Substantial disparities in SCI performance persist across country income groups in the Region, with average scores ranging from 47 in low-income countries to 81 in high-income countries (see Annex 1).

16. Furthermore, regional progress across the four SCI domains is uneven. The infectious diseases sub-index has improved the most, rising from 70 in 2015 to 78 in 2023, although significant gaps persist in fragile and conflict-affected situations. Reproductive, maternal, newborn and child health remains unchanged at 63, reflecting persistent challenges in coverage, continuity and equity. The noncommunicable diseases sub-index has also stagnated at 61, reflecting inadequate essential service coverage and slow progress in prevention and early detection. Service capacity and access remain the weakest sub-index, increasing only marginally from 52 in 2015 to 53 in 2023 due to workforce shortages, limited facilities and medicines, and low primary care readiness (1).

Health expenditure: low public spending and high household burden

17. Health spending patterns across the Eastern Mediterranean Region show substantial heterogeneity, shaped by country income levels, political commitment, fiscal capacity and the effects of fragility and conflict. Annex 3 provides an overview of health expenditure in the countries and territories of the Region in 2023, according to WHO's Global Health Expenditure Database (December 2025 update) (10).

⁸ Average numbers are calculated as a simple unweighted mean across countries classified in the three income groups listed in Annex 1.

⁹ The UHC SCI (SDG indicator 3.8.1) corresponds to the population-weighted geometric means of selected essential services spanning four health domains: reproductive, maternal, newborn and child health; infectious diseases; noncommunicable diseases; and service capacity and access. As an index score, the SCI cannot be directly interpreted as the percentage of the population covered by a set of essential services.

18. Current health expenditure (CHE) per capita ranges from US\$ 36 in low-income countries to US\$ 1603 in high-income countries. Despite this variation in absolute spending, CHE as a share of gross domestic product (GDP) is relatively similar across low- and middle-income settings (6.0–6.8%). CHE as a proportion of GDP is lower in high-income countries (2.5–5.7%); however, this reflects their larger economic base. Most countries with CHE below US\$ 60 per capita are fragile and conflict-affected situations. The regional average for health spending per capita (US\$ 574) is well below the global average (US\$ 1437) (10).¹⁰

19. Public financing for health also varies considerably across the Region. Domestic general government health expenditure (GGHE-D) per capita, as a measure of public spending, ranges from US\$ 3 in low-income countries to US\$ 99 in lower-middle-income countries, US\$ 218 in upper-middle-income countries and US\$ 1222 in high-income countries. The regional average for GGHE-D is US\$ 400 per capita, compared with a global average of US\$ 990 (10). It is worth noting that rising national income does not automatically lead to higher government spending on health. Policy choices matter.

20. GGHE-D as a share of CHE increases steadily with income level, rising from 12% in low-income countries to just under 45% in lower-middle-income countries, nearly 60% in upper-middle-income countries and more than 75% in high-income countries. Overall, public spending accounts for only 48% of CHE in the Region, compared with a global average of 53% (10).

21. Conversely, OOP payments as a share of CHE are exceptionally high in low-income countries (61%) and substantial in lower-middle-income (40%) and upper-middle-income countries (39%), declining significantly only in high-income countries (13%) (Fig. 1).

22. Government prioritization of health also varies significantly. GGHE-D as a share of general government expenditure (GGE) is 6% in low-income countries, 10% in lower-middle-income countries, 12% in upper-middle-income countries and 11% in high-income countries, indicating a limited allocation of fiscal space to health in many countries of the Region.

23. GGE as a proportion of GDP, indicating the fiscal space available, is 10% in low-income countries, 26% in lower-middle-income countries, 40% in upper-middle-income countries and 31% in high-income countries of the Region.

24. Over the years, the Region has accorded less priority to health compared to the global situation, dedicating one percentage point less of its GDP and GGE to health in comparison with global averages: in 2023, the Region invested on average 10% of its GGE and 3% of its GDP in health, compared with the global averages of 11% and 4%, respectively (10).

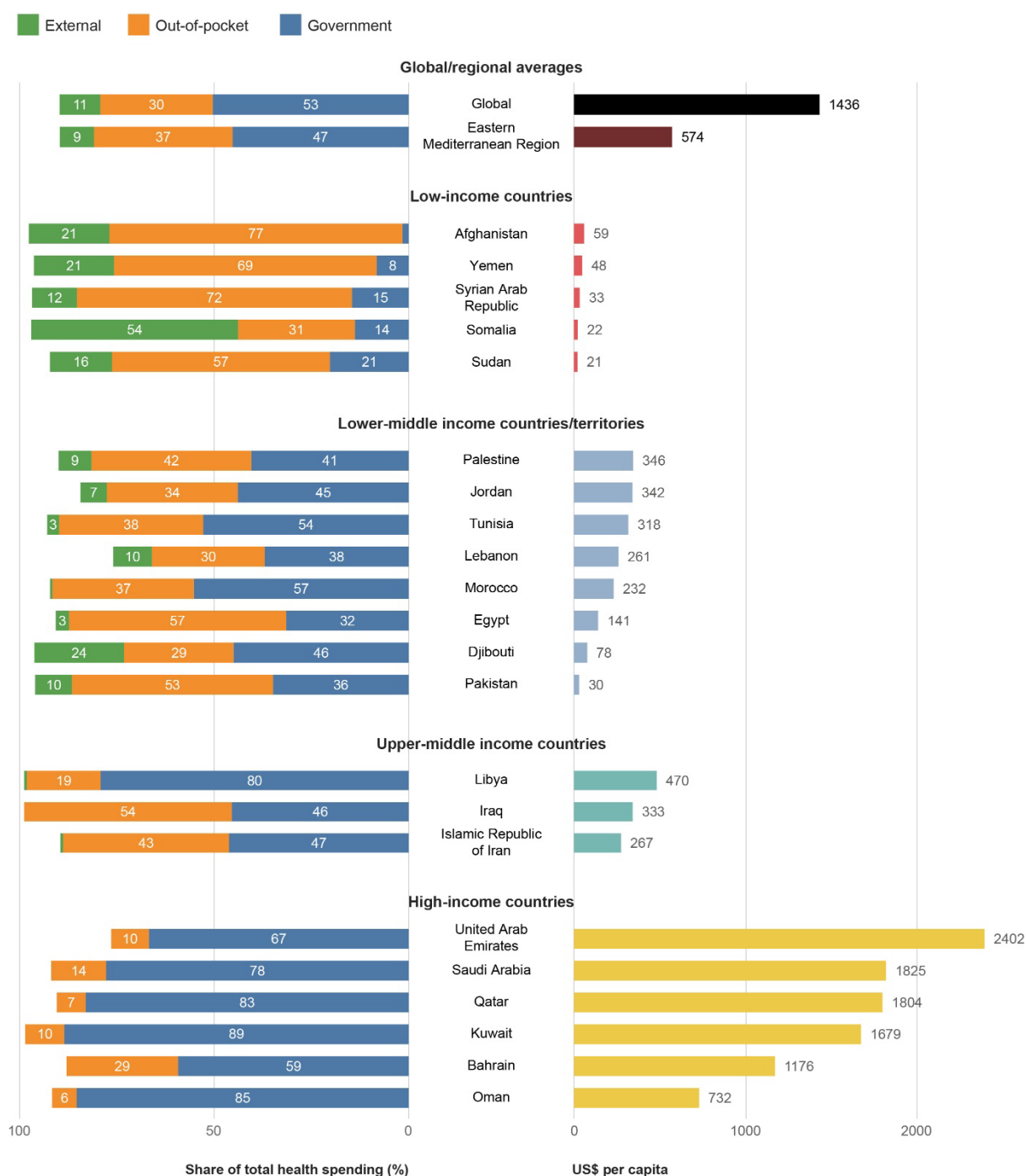
25. The fiscal space available for health in the Region has deteriorated in recent years due to the worsening economic situation in the Region as a result of multiple conflicts and global financial crises. In 2023, average GGE as a proportion of GDP in the Region was 26%, compared to 32% globally.

26. External funding remains a vital source of financing in poorer countries, constituting 25% of CHE in low-income countries in the Region, compared with 9% in lower-middle-income countries and 1% in upper-middle-income countries. By contrast, high-income countries rely entirely on domestic funding.

¹⁰ All average estimates reported in this analysis are unweighted averages, and each country was considered an equal unit of analysis.

Main financing sources, 2023 (% of health spending)

Health spending per capita, 2023 (US\$, current)



Note: Financing sources not presented include other private domestic sources, such as private insurance prepayments; global average excludes countries with a population less than 600 000.

Source: WHO Global Health Expenditure Database (December 2025 update) (10).

Fig. 1. Sources of health spending in countries and territories of the Eastern Mediterranean Region

Challenges to improving financial protection in the Region

27. Political instability and protracted conflicts remain major drivers of vulnerability across the Region. Many fragile and conflict-affected countries continue to rely heavily on humanitarian assistance, even as that funding declines and they contend with weakened health systems, fragile health financing arrangements and constrained public revenues.

28. While humanitarian assistance helps to reduce the cost of health care for crisis-affected populations, it typically covers only a limited package of essential and life-saving services. High-cost and specialized services, such as cancer treatment, dialysis, advanced surgery, rehabilitation and chronic disease management, are often inadequately covered. Moreover, humanitarian programmes target only the most vulnerable groups, leaving much of the population dependent on weak health systems even though they face the same challenging conditions. As a result, many households remain exposed to high OOP spending and financial hardship (11, 12).

29. The ongoing conflict in the Middle East has had significant spillover effects on economic performance across the Region, including the health sector. The Islamic Republic of Iran, already under long-standing economic sanctions, has experienced adverse health impacts due to shortages and rising prices of medicines and medical technologies, coupled with reduced household purchasing power (13, 14).

30. There is limited investment in essential public health functions to enhance health security. Essential public health functions are “a set of fundamental and interconnected activities and capacities both within and beyond the health sector”⁵ that offer a holistic, integrated and sustainable approach to public health by contributing to achieving several global and regional health priorities and goals (15, 16).

31. In many low-income countries and fragile and conflict-affected situations, official development assistance plays a critical role in strengthening financial protection by supporting essential health services, reducing reliance on OOP payments and expanding fiscal space for health. However, sustaining these gains can be challenging when donor funding declines or priorities shift. Long-term progress therefore depends on aligning external assistance with national priorities while strengthening domestic health financing capacity.

32. Public spending on health is insufficient in many countries in the Region. Although increased public spending alone does not automatically reduce OOP payments, it is foundational to building effective prepayment and risk-pooling mechanisms.

33. Gaps in health financing governance – including fragmentation in decision-making and weak health information systems – limit the design and implementation of sustainable health financing reforms. These gaps are reflected in low and uneven insurance coverage across the Region, with fragmented pooling arrangements that restrict effective risk sharing.

34. In many countries of the Region, health insurance coverage remains concentrated among formal-sector workers, leaving informal workers, unemployed people, refugees and other vulnerable populations largely unprotected (17). In high-income countries, nationals typically receive comprehensive benefits, while expatriate populations rely on separate and often variable schemes (18). High poverty rates, reaching 25–50% in some countries (19), together with weak integration between health financing and social protection systems, further increase household vulnerability.

35. Health systems across the Region continue to rely heavily on costly hospital-based and specialist services, while primary health care remains underdeveloped. This pattern increases health system expenditures and limits investment in preventive, promotive and community-based services, despite strong evidence that primary health care-oriented systems provide a more cost-effective and equitable pathway to UHC (20, 21).

36. Strategic purchasing remains underdeveloped in many countries across the Region, reducing the ability of purchasers to direct resources towards high-priority, cost-effective interventions and higher-performing

providers. In the absence of strategic purchasing arrangements that link funding decisions to population health needs and provider performance, opportunities to improve efficiency and equity are often missed (22, 23).

37. Input-based budgeting and fee-for-service payment mechanisms remain prevalent across many countries in the Region, limiting incentives for efficiency and quality improvement. Public financing is often allocated through historical line-item budgets, while providers are frequently paid based on the volume of services delivered rather than health outcomes or performance. These arrangements can encourage unnecessary service utilization, weaken accountability for results and contribute to rising health expenditures (24, 25).

38. Broader health system inefficiencies further reduce value for money and constrain progress towards UHC in the Region. Fragmented risk pools, weak referral systems and overreliance on specialist and hospital care increase costs without commensurate gains in health outcomes (26). These inefficiencies limit fiscal space for expanding coverage and reducing OOP spending, thereby weakening financial protection (27, 28).

39. These challenges are compounded by weak regulation of a rapidly expanding private health sector in the Region. Insufficient oversight of prices, quality, contracting arrangements and provider practices can contribute to cost escalation, variations in quality of care and inequities in access. In the absence of effective regulation, households may face higher OOP payments, unnecessary services and unpredictable health expenditures (17, 29, 30).

40. The high cost of medicines and health technologies represents a major financial burden on households when they are not covered and have to pay out of pocket. In some countries in the Region, pharmaceutical spending accounts for up to 54% of OOP expenditure, according to the Global Health Expenditure Database. Fragmented supply chains, limited pooled procurement mechanisms and insufficient promotion of generic medicines restrict access to affordable essential products.

41. These pressures are intensified by the high burden of noncommunicable diseases, which account for 66% of all deaths in the Region (31). Conditions such as diabetes and cancer generate significant direct and indirect costs for households and health systems. Limited coverage of outpatient care and the high cost of medicines for noncommunicable disease are major drivers of OOP spending (32–34). In addition, mental health services remain largely uncovered by insurance mechanisms in the Region, imposing long-term financial strain on affected households (33, 34).

Regional response to enhance financial protection

42. Despite these challenges, most countries in the Region have undertaken comprehensive or incremental reforms to strengthen health financing and enhance financial protection. Annex 4 highlights selected examples of country initiatives from across the Region.

43. High-income countries have focused on implementing insurance reforms to expand mandatory coverage, particularly for expatriate populations, while strengthening regulation, strategic purchasing and provider payment mechanisms to improve efficiency, sustainability and value for money. Reforms in Bahrain, Saudi Arabia and the United Arab Emirates combine mandatory insurance with investments in service delivery capacity, standardized benefits packages, enhanced purchasing arrangements and, in some contexts, innovative Islamic financing models.

44. Middle-income countries are pursuing structural reforms aimed at reducing fragmentation and OOP health spending. Examples include securing political commitment for implementation of Egypt's Universal Health Insurance Law; advancing post-war recovery and health financing reform in Iraq through the phased rollout of Health Insurance Law No. 22 of 2020; implementing a UHC and health financing reform agenda in Jordan; expanding financial protection through Pakistan's Sehat Sahulat Program/Card; and promoting equity and efficiency through unified health insurance reform in Tunisia.

45. Low-income countries and fragile and conflict-affected situations have focused on restoring core health financing functions, protecting households from financial hardship caused by OOP health spending and

ensuring the continuity of essential health services amid instability. The following pragmatic initiatives illustrate how countries are adapting their approaches to strengthen financial protection under severe fiscal, political and operational constraints: use of health taxation and governance reforms to expand fiscal space and improve system performance in Lebanon; monitoring of financial hardship and development of an affordable essential health services package in Palestine; and pooled procurement of high-cost medicines in Sudan.

Framework for action to advance health financing for stronger financial protection in the Eastern Mediterranean Region

46. Drawing on global and regional experience, this paper proposes a framework for action to advance health financing for stronger financial protection in the Region, which outlines a set of four strategic directions and associated priority actions, while acknowledging that priorities will differ from country to country.

Strategic direction 1. Strengthening public financing for health

47. This strategic direction focuses on strengthening public financing for health through expanded fiscal space, improved revenue raising and greater prioritization of health within national budgets. It also emphasizes the importance of leveraging and regulating private financing effectively. In parallel, enhancing the effectiveness and predictability of official development assistance, through stronger alignment with national financing frameworks and clear transition plans, is essential to support sustainability and reinforce country ownership.

48. Innovative financing approaches and new revenue-raising mechanisms – including Islamic finance, blended finance and climate-related financing – may further expand the resources available for health and contribute to strengthening financial protection. In this context, Islamic financing models offer complementary, faith-based mechanisms to support health financing in the Region. Instruments such as *zakat*, *waqf*, *takaful* and *sukuk*, which are grounded in principles of equity, solidarity and risk-sharing, can help to finance services for vulnerable populations, strengthen pooling arrangements and enhance financial protection. When effectively governed and integrated into national systems, these mechanisms can contribute to more sustainable domestic health financing systems.

49. Multilateral development banks and bilateral partners remain important sources of financing and technical support for health, particularly in countries facing fiscal constraints. Beyond grants and concessional financing, they can support reforms that strengthen public financing, improve spending efficiency and advance financial protection. Initiatives such as the Health Impact Investment Platform provide opportunities to align partner financing and technical assistance with country-led health priorities, while promoting country ownership and supporting a gradual transition to sustainable domestic financing.

50. Health economics is critical for generating the evidence needed to strengthen public financing for health and inform policy decisions. It can also strengthen advocacy for health investment, inform dialogue with ministries of finance and development partners, and guide reforms that enhance financial protection, reduce unmet need and accelerate progress towards UHC.

Priority actions

- Develop and implement a well-defined national health financing strategy linked to a medium-term expenditure framework, with clear priorities, resource requirements and expected outcomes.
- Prioritize health within the overall public budget to increase public financing for health through general government revenues, mandatory social health insurance contributions or a combination of the two.
- Introduce or expand health taxes that both generate revenue and promote health. Where appropriate, use the revenue generated to improve access to essential health services and strengthen financial protection.
- Leverage private financing in alignment with public policy objectives, including through public–private partnerships and innovative financing approaches such as Islamic finance instruments.

- Draw on multilateral development bank financing, blended finance and initiatives such as the Health Impact Investment Platform to mobilize additional resources for health and support country-led health financing reforms.
- Strengthen the alignment of external assistance with national health financing strategies, including through a humanitarian–development–peace nexus approach in fragile and conflict-affected situations, and promote on-budget and on-system financing wherever feasible.

Strategic direction 2. Advancing equity in financial protection

51. Equitable financial protection is achieved when people, especially the poorest and most vulnerable, can obtain needed health services without financial hardship and without having to forgo care because of cost or other access barriers. Financial protection should therefore be pursued alongside equitable access to health services, recognizing that unmet need due to financial barriers is itself a manifestation of inadequate financial protection.

52. Achieving this requires a people-centred model of care that ensures services are available, accessible, affordable and of adequate quality across the continuum of care, with particular attention to poor, vulnerable and underserved populations (35). Health systems must address both financial and non-financial barriers that prevent people from seeking and receiving care, thereby reducing unmet need and improving equitable access to services.

53. Advancing equity in financial protection requires targeted measures that prioritize disadvantaged populations and ensure that health financing arrangements redistribute resources according to health need, while contributing to equitable access to needed services.

Priority actions

- Define and harmonize an evidence-based package of health services across all financing arrangements, financed predominantly through public revenues and compulsory prepayment mechanisms, to promote equitable access to care and financial protection for all.
- Develop and implement a primary health care-oriented model of care that promotes first-contact access, continuity and coordination of care, while reducing unmet need and advancing equity in access and financial protection, particularly for poor, vulnerable and underserved populations.
- Ensure public subsidies are provided through direct budget transfers to public facilities or compulsory health insurance, with a focus on primary care and on poor, vulnerable, underserved and hard-to-reach populations, to improve equity in access to services and strengthen financial protection.
- Align complementary health financing arrangements, including private insurance schemes and contributions from nongovernmental organizations and faith-based actors, with national health financing policies and objectives to improve equity in financial protection.

Strategic direction 3. Improving efficiency and value for money in health spending

54. Improving efficiency and value for money in health spending is essential to sustain progress towards equitable financial protection in the context of constrained fiscal space and growing demands on health systems.

55. WHO estimates that between 20% and 40% of health spending is lost to inefficiencies, making efficiency gains a major source of fiscal space for expanding coverage and strengthening financial protection. Addressing these inefficiencies can free up resources for higher-priority services, reduce unmet need and improve health outcomes, equity and financial protection (27).

56. A central pillar of this agenda is increasing and reallocating public spending towards primary health care. Strong primary health care systems contribute to both efficiency and financial protection by providing accessible, cost-effective preventive and essential services and reducing avoidable hospital utilization.

57. Reforms to provider payment mechanisms, supported by public financial management reforms and strategic purchasing, are critical to aligning incentives with efficiency, quality, equity and people-centred care. At the system level, reducing fragmentation in financing and purchasing arrangements, strengthening procurement and supply chain systems, and leveraging digital and artificial intelligence (AI)-enabled health financing information systems can improve resource allocation, reduce waste and costs, and enhance transparency, accountability and performance.

Priority actions

- Increase and reallocate public resources towards primary health care, through both budgetary allocations and insurance payments, to improve allocative efficiency, strengthen financial protection and enhance overall system performance.
- Strengthen strategic purchasing and priority-setting mechanisms to ensure that resources are allocated to cost-effective interventions, services and technologies that maximize health outcomes, equity and financial protection.
- Reform provider payment methods, supported by public financial management reforms, to strengthen incentives for efficiency, quality, equity and continuity of care.
- Reduce fragmentation in financing and purchasing arrangements to enhance administrative efficiency, risk sharing, coherence and purchasing power.
- Strengthen procurement, supply chain and logistics systems, including for medicines and health technologies, to lower costs, minimize waste and improve the availability and affordability of essential health products.
- Leverage digital and AI-enabled approaches to improve efficiency in health service provision and strengthen health and financial management information systems to support service delivery, strategic purchasing, expenditure management, performance monitoring and accountability.

Strategic direction 4. Enhancing health financing governance and institutional capacity for effective implementation

58. Strong governance and institutional capacity are essential for effective health financing systems, ensuring the transparent, accountable and efficient use of resources. They enable health financing policies to be translated into sustainable improvements in service coverage and financial protection.

59. Well-functioning health financing systems are inclusive and participatory, incorporating community perspectives, appropriately regulating private-sector involvement and ensuring public accountability for the management and use of funds. Political acceptability is equally important; trust, legitimacy and consensus-building are critical for the design, adoption and implementation of health financing reforms.

60. Transparency is a cornerstone of good health financing governance. Transparent budgeting, spending, purchasing and reporting processes strengthen accountability, build public trust and support evidence-informed decision-making, while helping to reduce inefficiencies and misuse of resources.

61. Robust public financial management and integrated health financing information systems are essential for good governance, enabling credible budgeting, transparent resource tracking and evidence-informed decision-making, including monitoring of financial protection and equity. This requires sustained investment in institutional and technical capacities across the health financing system.

Priority actions

- Clarify institutional roles, responsibilities and accountabilities across the health financing architecture, and strengthen the capacities of key actors, including ministries of health and finance, health insurance agencies and regulatory bodies.

- Strengthen public financial management systems to improve budget credibility, execution, transparency and efficiency, while making effective use of existing flexibilities to support timely and responsive resource allocation.
- Institutionalize health expenditure tracking, financial protection monitoring and routine performance assessment to support evidence-informed policy-making, transparency and accountability.
- Strengthen coordination between health financing and social protection systems, including cash-transfer programmes and social insurance schemes, to improve coverage, targeting and financial protection for poor and vulnerable populations.
- Establish mechanisms to rapidly scale up public financing during crises, including conflicts, disease outbreaks and pandemics, sanctions and climate-related emergencies, to ensure continuity of essential health services and financial protection.
- Operationalize the Eastern Mediterranean Region Health Financing Taskforce to provide strategic guidance, technical support and knowledge exchange for health financing reforms, while strengthening collaboration among Member States, WHO and development partners.

Differentiated priorities across countries in the Region

62. While fiscal capacity, institutional maturity and levels of stability vary across countries in the Region, all countries share common strategic directions towards advancing health financing systems and strengthening financial protection, which can be framed around three mutually reinforcing objectives: *investing in foundations, building/strengthening institutions and driving transformations*. These objectives represent a continuum from establishing system readiness for health financing reform to achieving effective implementation and sustainable impact. However, countries may differ in their starting points.

63. In general, *high-income countries* are more likely to prioritize driving transformations to enhance efficiency, value for money and equity. *Middle-income countries* may focus on building/strengthening institutions to address fragmentation, improve pooling arrangements and reduce OOP spending. *Low-income countries* often need to prioritize investing in the foundations of sustainable health financing systems, including core governance, financing and information system functions. *In fragile and conflict-affected situations*, priorities may focus on stabilizing financing arrangements and maintaining continuity of essential services, while laying the groundwork for longer-term recovery and reform.

64. However, these categories are not prescriptive, and countries may face challenges that cut across all three objectives. For example, some high-income countries may still need to strengthen foundational elements such as the institutionalization of National Health Accounts or financial protection monitoring, while some middle-income countries may need to advance reforms related to the regulation and integration of coverage arrangements for non-citizens and expatriate workers. Country priorities should therefore be informed by a comprehensive assessment of the health financing system, including its progress and maturity, and by the overall context of reform. WHO's Health Financing Progress Matrix (36), together with other diagnostic tools, can support the identification of priorities and guide pathways to reform.

65. The following are illustrative actions that countries may consider under each objective, depending on their context and stage of health financing system development.

- *Investing in foundations* focuses on establishing the essential policy, legal, financing and system prerequisites needed to ensure the availability of quality health services and protect people from financial hardship. Key actions include: establishing legal and policy frameworks for health financing; investing in essential public health functions; defining priority health service and benefit packages; mobilizing domestic revenues and sustainable financing sources; introducing prepayment and pooling mechanisms; and developing core information systems for expenditure tracking and financial protection monitoring. These efforts should be accompanied by measures to support the sustainable delivery of health services and the availability and affordability of medicines and other health products, including reducing financial barriers to access, strengthening public financial management and investing in primary health care to promote equity and financial protection.

- *Building/strengthening institutions* focuses on the governance arrangements, organizational capacities and operational mechanisms required to manage and sustain health financing functions effectively. Key actions include: clarifying the roles and responsibilities of health, finance and insurance agencies; strengthening public financial management and accountability systems; developing strategic purchasing institutions and mechanisms; enhancing the regulation of private financing and service provision; and institutionalizing health expenditure tracking, financial protection monitoring and performance assessment. Strengthening technical capacity in areas such as costing, provider payment systems and health economics is also essential to support effective implementation and oversight.
- *Driving transformations* focuses on enabling health financing systems to adapt to evolving population needs, fiscal realities and health system challenges while advancing UHC and financial protection. This includes responding to population ageing, the growing burden of noncommunicable diseases, transitions from external assistance to domestic financing, and shifts from emergency response to recovery and development in fragile and conflict-affected situations. Key actions include: refining benefit packages; strengthening oversight of private providers and insurers; improving arrangements for covering non-citizens and expatriate workers; and advancing strategic purchasing, provider payment reforms, and efficiency and cost-containment measures. These reforms help to ensure that health financing systems remain equitable, sustainable and responsive while enhancing financial protection.

66. Across all contexts, Member States will lead health financing reforms and stakeholder engagement. WHO will provide technical and normative guidance, while enabling learning and coordination, in addition to facilitating national and inclusive policy dialogues on health financing reform for UHC and health security. Development partners will contribute catalytic financing and investments to support the expansion and sustainability of country-led reforms aligned with national priorities.

Conclusion

67. Strengthening financial protection is essential to achieving UHC in the Eastern Mediterranean Region. Persistently high levels of OOP spending, unmet need for health services, inequities in access to care and fragmented financing arrangements continue to expose many households to financial hardship and undermine progress towards UHC.

68. Despite diverse country contexts, shared structural challenges call for sustained health financing reforms to improve financial protection, guided by four strategic directions: strengthening public financing for health; advancing equity in financial protection; improving efficiency and value for money in health spending; and enhancing health financing governance and institutional capacity. The pace and sequencing of reforms will vary according to country circumstances.

69. Strong political commitment, cross-sectoral collaboration and coordinated support from WHO and partners will be critical to ensure stronger financial protection and equitable access to care across the Region amid growing pressures.

References¹¹

1. World Health Organization & International Bank for Reconstruction and Development/The World Bank. Tracking universal health coverage: 2025 global monitoring report. Geneva: World Health Organization; 2025 (<https://iris.who.int/handle/10665/384883>). Licence: CC BY-NC-SA 3.0 IGO.
2. FY26 list of fragile and conflict-affected situations. Washington, DC: World Bank; 2025 (<https://thedocs.worldbank.org/en/doc/5c7e4e268baaafa6ef38d924be9279be-0090082025/original/FCSListFY26.pdf>).
3. Classification of fragility and conflict situations (FCS) for World Bank Group engagement. Washington, DC: World Bank; 2023 (<https://thedocs.worldbank.org/en/doc/fb0f93e8e3375803bce211ab1218ef2a-0090082023/original/Classification-of-Fragility-and-Conflict-Situations-FY24.pdf>).
4. Strategic directions to improve health care financing in the Eastern Mediterranean Region: moving towards universal coverage 2011–2015. Cairo: WHO Regional Office for the Eastern Mediterranean; 2010 (EM/RC57/R.7; <https://iris.who.int/handle/10665/122914>).
5. Salalah Declaration on Universal Health Coverage 2018: the road to universal health coverage in the Eastern Mediterranean Region. Cairo: WHO Regional Office for the Eastern Mediterranean; 2018 (https://www.emro.who.int/images/stories/health-topics/uhc/salalah_uhc_declaration_-_final.pdf).
6. Building resilient health systems to advance universal health coverage and ensure health security in the Eastern Mediterranean Region. Cairo: WHO Regional Office for the Eastern Mediterranean; 2022 (EM/RC69/R.2; <https://iris.who.int/handle/10665/371220>).
7. Seventy-eighth World Health Assembly, Geneva, 19–27 May 2025: resolutions and decisions, annexes. Geneva: World Health Organization; 2025 (WHA78.12; <https://iris.who.int/handle/10665/385724>).
8. Strategic operational plan for the Eastern Mediterranean Region 2025–2028. Cairo: WHO Regional Office for the Eastern Mediterranean; 2025 (<https://iris.who.int/handle/10665/381267>). Licence: CC BY-NC-SA 3.0 IGO.
9. A global health strategy for 2025–2028 – advancing equity and resilience in a turbulent world: fourteenth general programme of work. Geneva: World Health Organization; 2025 (<https://iris.who.int/handle/10665/380456>). Licence: CC BY-NC-SA 3.0 IGO.
10. Global health expenditure database (December 2025 update) [online database]. World Health Organization; 2025 (<https://apps.who.int/nha/database>).
11. Birk HO, Vrangbæk K, Rudkjøbing A, Krasnik A, Horschig M, Eriksen A, et al. Denmark: health system summary, 2024. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies; 2024 (<https://eurohealthobservatory.who.int/publications/i/denmark-health-system-summary-2024>).
12. Birk HO, Vrangbæk K, Rudkjøbing A, Krasnik A, Eriksen A, Richardson E, et al. Denmark: health system review. *Health Syst Transit*. 2024;25(6):i–152. PMID:38841877.
13. Danaei G, Harirchi I, Sajadi H, Yahyaei F, Majdzadeh R. The harsh effects of sanctions on Iranian health. *Lancet*. 2019;394:468–69. doi:10.1016/S0140-6736(19)31763-5. Erratum in: *Lancet*. 2019;394(10201):830. doi:10.1016/S0140-6736(19)31945-2.
14. Baradaran-Seyed Z, Majdzadeh R. Economic sanctions strangle Iranians' health, not just drug supply. *Lancet*. 2013;381:1626. doi:10.1016/S0140-6736(13)61024-7.
15. Zhang Y, McDarby G, Seifeldin R, Mustafa S, Dalil S, Schmets G, et al. Towards applying the essential public health functions for building health systems resilience: a renewed list and key enablers for operationalization. *Front Public Health*. 2022; 10:1107192 (<https://doi.org/10.3389/fpubh.2022.1107192>).
16. Mohamed-Ahmed O, Aboutaleb H, Latif S, Watson HL, Handley R, Humphreys E, et al. Reviewing essential public health functions in the Eastern Mediterranean Region post COVID-19

¹¹ All references were accessed on 7 September 2026.

- pandemic: a foundation for system resilience. *BMJ Glob Health*. 2024 Mar 28;9(3):e013782 (<https://doi.org/10.1136/bmjgh-2023-013782>).
17. Zaidi S, Thabet A, Salah H, Clarke D, Mataria A. Government purchase of private health services in the Eastern Mediterranean Region: opportunities and challenges for stewarding towards a universal health coverage focus. *BMJ Glob Health*. 2025;8:e017435 (<https://doi.org/10.1136/bmjgh-2024-017435>).
 18. Elrabbat M, Rawaf S, Lami F, Hussein A, Elkady H, Al Nsour M. State of public health in the Eastern Mediterranean: challenges and opportunities: an analysis. *The Eastern Mediterranean Public Health Network (EMPHNET)*; 2025 (https://emphnet.net/media/tdajt5fy/state-of-public-health-in-the-emr_challenges-and-opportunities-english.pdf).
 19. Building resilient health systems to advance universal health coverage and ensure health security in the Eastern Mediterranean Region. Cairo: WHO Regional Office for the Eastern Mediterranean; 2022 (EM/RC69/4; <https://iris.who.int/handle/10665/366621>).
 20. Universal health coverage [website]. World Health Organization; 2026 (<https://www.who.int/health-topics/universal-health-coverage>).
 21. Primary health care: an integrated approach for delivering universal health coverage with a focus on social justice, equity, and solidarity. Technical brief. Geneva: World Health Organization; 2022 (<https://www.who.int/publications/m/item/primary-health-care.-an-integrated-approach-for-delivering-universal-health-coverage-with-a-focus-on-social-justice--equity--and-solidarity>).
 22. Promoting strategic purchasing [website]. World Health Organization; 2026 (<https://www.who.int/activities/promoting-strategic-purchasing>).
 23. Mathauer I, Dale E, Jowett M, Kutzin J. Purchasing health services for universal health coverage: How to make it more strategic? Geneva: World Health Organization; 2019 (<https://iris.who.int/handle/10665/311387>). License: CC BY-NC-SA 3.0 IGO.
 24. Moradi T, Kabir MJ, Pourasghari H, Ehsanzadeh SJ, Aryankhesal A. Challenges of budgeting and public financial management in Iran's health system: a qualitative study. *Med J Islam Repub Iran*. 2023;17;37:80. doi:10.47176/mjiri.37.80.
 25. Health financing progress matrix assessment, Jordan 2024: summary of findings and recommendations. Cairo: WHO Regional Office for the Eastern Mediterranean; 2024 (<https://iris.who.int/handle/10665/379932>). Licence: CC BY-NC-SA 3.0 IGO.
 26. Pourmohammadi K, Shojaei P, Rahimi H, Bastani P. Evaluating the health system financing of the Eastern Mediterranean Region (EMR) countries using Grey Relation Analysis and Shannon Entropy. *Cost Eff Resour Alloc*. 2018;16:31 (<https://doi.org/10.1186/s12962-018-0151-6>).
 27. The world health report: health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010 (<https://iris.who.int/handle/10665/44371>).
 28. Brief: health financing [website]. World Bank; 2026 (<https://www.worldbank.org/en/topic/health/brief/health-financing>).
 29. Governance of the private healthcare sector in low- and middle-income countries: a scoping review of approaches, effectiveness, and enablers. Geneva: World Health Organization; 2024 (<https://iris.who.int/handle/10665/379381>). License: CC BY-NC-SA 3.0 IGO.
 30. The World Bank Group's approach to private healthcare. Washington, DC: World Bank Group; 2025 (<https://www.ifc.org/content/dam/ifc/doc/2025/wbg-approach-to-private-health-care.pdf>).
 31. Turning resolutions into results: accelerating action on noncommunicable diseases in the Eastern Mediterranean Region [website]. WHO Regional Office for the Eastern Mediterranean; 2025 (<https://www.emro.who.int/media/news/turning-resolutions-into-results-accelerating-action-on-noncommunicable-diseases-in-the-eastern-mediterranean-region.html>).
 32. Elmusharaf K, Mairghani M, Poix S, Scaria E, Phyo PP, Thu W, et al. A cost of illness study of the economic burden of diabetes in the Eastern Mediterranean Region. *East Mediterr Health J*. 2025;31(7):426–35 (<https://doi.org/10.26719/2025.31.7.426>).
 33. Shaltynov A, Jamedinova U, Semenova Y, Abenova M, Myssayev A. Inequalities in out-of-pocket health expenditure measured using financing incidence analysis (FIA): a systematic review. *Healthcare (Basel)*. 2024;12:1051 (<https://doi.org/10.3390/healthcare12101051>).

34. Saving lives, spending less: the global investment case for noncommunicable diseases. Geneva: World Health Organization; 2025 (<https://iris.who.int/handle/10665/382853>). Licence: CC BY-NC-SA 3.0 IGO.
35. Al Asfoor D, Kasper T, Ravaghi H, Mataria A. Untangling ambiguity: what is a primary health care-oriented model of care? Arch Pub Health Pract Policy. 2026;3(1):107. doi:10.33425/2834-4227.1007.
36. Health Financing Progress Matrix [website]. World Health Organization; 2026 (<https://www.who.int/teams/health-financing-and-economics/health-financing/diagnostics/health-financing-progress-matrix>).

Annex 1

Service coverage and financial hardship and its components in the countries and territories of the Eastern Mediterranean Region

Country/territory	Service coverage index (2023)	Financial hardship (% of population)	Impoverishing OOP health expenditure (% of population)	Large but non-impoverishing OOP health expenditure (% of population)	Financial hardship latest year ^{a,b}	Household data older than 5 years	Household data older than 10 years
Low income							
Afghanistan	42.0	34.6	NA	NA	2020	Yes	No
Somalia	30.0	35.9	NA	NA	2017	Yes	No
Sudan	48.0	39.9	31.8	8.1	2014	Yes	Yes
Syrian Arab Republic	70.0	16.0	12.0	4.0	2007	Yes	Yes
Yemen	43.0	30.1	24.9	5.3	2014	Yes	Yes
Lower-middle income							
Djibouti	47.0	6.5	5.7	0.8	2017	Yes	No
Egypt	71.0	36.9	21.1	15.9	2019	Yes	No
Jordan	74.0	14.7	13.4	1.3	2010	Yes	Yes
Lebanon	67.0	33.3	18.7	14.6	1999	Yes	Yes
Morocco	65.0	27.1	20.5	6.6	2013	Yes	Yes
Pakistan	56.0	33.9	28.5	5.4	2018	Yes	No
Palestine	65.0	22.3	18.8	3.5	2023	No	No
Tunisia	76.0	31.2	18.3	12.8	2021	No	No
Upper-middle income							
Iran (Islamic Republic of)	81.0	15.6	11.3	4.4	2022	No	No
Iraq	64.0	33.2	24.6	8.5	2017	Yes	No
Libya	71.0	NA	NA	NA	NA	NA	NA
High income							
Bahrain	78.0	NA	NA	NA	2023 ^c	NA	NA
Kuwait	84.0	NA	NA	NA	2023 ^c	NA	NA
Oman	74.0	8.5	7.8	0.7	1999	Yes	Yes
Qatar	84.0	NA	NA	NA	2023 ^c	NA	NA
Saudi Arabia	83.0	NA	NA	NA	2023 ^c	NA	NA
United Arab Emirates	84.0	NA	NA	NA	2023 ^c	NA	NA

OOP: out-of-pocket; NA: not available.

^a Based on: World Health Organization, International Bank for Reconstruction and Development & World Bank (2023). Tracking universal health coverage: 2023 global monitoring report. Geneva: World Health Organization; 2023 (<https://iris.who.int/handle/10665/374059>). Licence: CC BY-NC-SA 3.0 IGO.

^b Based on: World Health Organization & International Bank for Reconstruction and Development/The World Bank. Tracking universal health coverage: 2025 global monitoring report. Geneva: World Health Organization; 2025 (<https://iris.who.int/handle/10665/384883>). Licence: CC BY-NC-SA 3.0 IGO.

^c Estimates produced based on definitions in the 2023 global monitoring report.

Note: Country data are based on information collected for the 2025 global monitoring report and validated through a country consultation exercise conducted in April and May 2025. As a result, they may not fully reflect the most recent data available at the national level. The next country consultation is scheduled for Q1 2027, with updated results expected to be released in Q3 2027.

Source: The Global Health Observatory: financial hardship due to out-of-pocket health spending and its components (SDG 3.8.2, 2025 definition) [online database]. World Health Organization; 2025 (<https://www.who.int/data/gho/data/themes/topics/financial-protection>).

Annex 2

Financial hardship by demographic and socioeconomic group in the Eastern Mediterranean Region (average percentage of the population in each group)^a

Income group	Consumption quintile					Residence area		Sex of head of household		Age group of head of household		Household composition				
	Q1 Lowest consumption levels	Q2	Q3	Q4	Q5 Highest consumption levels	Rural	Urban	Male	Female	Below 60 years old	60 years of age and older	Adults only (20–59 years)	Adults with children and/or adolescents	Adults with older persons	Multi- generational households	Only older adults (≥ 60 years old)
Low income	60.4	48	21.5	14.2	12.4	31.9	19.1	32	31.5	31.2	32.2	8.6	31.1	20.3	34.4	10.3
Lower-middle income	72.3	34.3	11.1	6.5	4.4	21.2	13.4	22	17.8	22	20.3	7.1	22.2	13.5	28.3	11.3
Upper-middle income	47.5	22	4.3	3.8	2.7	19.9	15.1	16	18.8	16.4	16.2	2.5	16.6	11.4	23.1	3.2
High income	NA	NA	NA	NA	NA	1.9	1.2	NA	NA	NA	NA	NA	NA	NA	NA	NA

NA: not available.

^a Average rates are unweighted averages calculated based on the country-level data available in the Global database on financial protection assembled by WHO and the World Bank (2025 update).

Source: The Global Health Observatory: financial hardship due to out-of-pocket health spending and its components (SDG 3.8.2, 2025 definition) [online database]. World Health Organization; 2025 (<https://www.who.int/data/gho/data/themes/topics/financial-protection>).

Annex 3

Health expenditure in countries and territories of the Eastern Mediterranean Region, 2023

Country/territory	CHE per capita (US\$)	CHE as a share of GDP (%)	GGHE-D per capita (US\$)	GGHE-D as % GGE	GGHE-D as % CHE	GGHE-D as % GDP	GGE as % GDP	OOP spending as % of CHE	Latest NHA study or latest OOP spending household survey (GHED 2025)
Low income									
Afghanistan	59	15.0	1	1.5	2	0.2	17	77	2011–2022 based on SHA2011; 2017–2018 (HHS-OOP)
Somalia	22	3.7	3	7.9	14	0.5	7	31	No NHA. Data estimated by WHO
Sudan	21	2.9	4	7.1	21	0.6	8	57	2018 and 2020 based on SHA2011
Syrian Arab Republic	33	2.7	5	7.7	15	0.4	5	72	No NHA. Data estimated by WHO
Yemen	48	9.7	4	7.0	8	0.8	12	69	2019–2021 based on SHA2011
Lower-middle income									
Djibouti	78	2.3	36	4.9	46	1.1	22	29	2011–2014 based on SHA2011
Egypt	141	4.9	46	6.9	32	1.6	23	57	2020 based on SHA2011
Jordan	342	7.7	154	10.5	45	3.4	33	34	2018–2022 based on SHA2011
Lebanon	261	5.6	99	15.9	38	2.1	13	30	2012, 2015–2017 and 2019–2021 based on SHA2011
Morocco	232	6.1	131	10.6	57	3.4	32	37	2022 based on SHA2011
Pakistan	30	2.5	11	4.7	36	0.9	19	53	Data for seven years (2006–2022) based on SHA 1.0
Palestine	346	10.7	143	14.4	41	4.4	31	42	2014–2023 based on SHA2011
Tunisia	318	8.0	172	12.1	54	4.3	36	38	2011–2015 and 2019 based on SHA2011
Upper-middle income									
Iran (Islamic Republic of)	267	6.0	125	19.1	47	2.8	15	43	2000–2021 based on SHA 1.0
Iraq	333	5.5	153	6.2	46	2.5	41	54	2016–2021 and 2023 based on SHA2011; 2017 (HHS-OOP)
Libya	470	7.8	377	9.6	80	6.3	65	19	No NHA. Data estimated by WHO
High income									
Bahrain	1176	4.0	697	8.5	59	2.4	28	29	2012–2016 based on SHA2011
Kuwait	1679	5.0	1487	9.0	89	4.4	49	10	No NHA. Data estimated by WHO
Oman	732	3.5	625	10.8	85	3.0	27	6	No NHA. Data estimated by WHO
Qatar	1804	2.5	1498	7.7	83	2.1	27	7	2011–2014 based on SHA2011
Saudi Arabia	1825	5.7	1419	13.7	78	4.4	32	14	2017–2023 based on SHA2011
United Arab Emirates	2402	5.0	1604	14.4	67	3.3	23	10	2017–2018 and 2020–2023 based on SHA2011

CHE: current health expenditure; GDP: gross domestic product; GGE: general government expenditure; GGHE-D: domestic general government health expenditure; GHED: Global Health Expenditure Database; HHS: household survey; NHA: National Health Accounts; OOP: out-of-pocket; SHA: System of Health Accounts.

Source: Global Health Expenditure Database (December 2025 update) [online database]. World Health Organization; 2025 (<https://apps.who.int/nha/database>).

Annex 4

Examples of country initiatives in the Eastern Mediterranean Region for strengthening health financing to enhance financial protection

Bahrain – Transforming the national health insurance programme while strengthening service delivery capacity

Bahrain is undertaking a major transformation of its health financing system through the implementation of the National Health Insurance Program (Sahti), established under the National Health Insurance Law No. 23 of 2018. The reform aims to create a flexible and sustainable system that ensures equitable access to health care and allows individuals to choose their health-care providers. Sahti shifts the country towards an insurance-based model administered by the Health Insurance Fund, which manages registration, contribution collection and contracting with service providers.

A central component is the rollout of mandatory health insurance for expatriates and visitors, extending coverage to more than 686 000 expatriate residents and 1.6 million annual visitors. This measure is supported by an investment of 688 million Bahraini dinars to expand and upgrade health facilities, reduce pressure on public hospitals and enhance system sustainability. Complementary reforms focus on strategic purchasing, efficiency improvements and strengthening service delivery capacity, highlighting Bahrain's commitment to building a high-quality, sustainable health system aligned with universal health coverage (UHC) goals (1, 2).

Egypt – Garnering political commitment to implement the Universal Health Insurance Law

Egypt is implementing a major health system transformation to address chronic underinvestment, high out-of-pocket (OOP) spending and inefficiencies in health financing. Central to this reform is the Universal Health Insurance Law, now in force in six governorates and scheduled for nationwide rollout by 2032. The law introduces a modern governance structure that separates financing, service provision and quality regulation to enhance accountability and system performance. A phased expansion of mandatory family coverage aims to merge Egypt's fragmented schemes into a single national risk pool, strengthening equity and financial protection.

The reform diversifies revenue through income-based contributions, state subsidies for vulnerable groups and earmarked taxes. It seeks to improve purchasing mechanisms and regulated cost-sharing by expanding access, increasing efficiency and reducing financial hardship. Government health spending rose by 44% between 2019 and 2023, reflecting political commitment, though overall levels remain low regionally.

Early evidence shows improved patient satisfaction and declining OOP payments, but challenges persist in securing sustainable financing, engaging private providers and defining a balanced benefits package (3–8).

Iraq – Achieving post-war recovery and health financing system reform

Iraq is undertaking a major reform during the post-war recovery period to strengthen financial protection and advance progress towards UHC through the phased rollout of Health Insurance Law No. 22 of 2020, which establishes the foundation for a national health insurance scheme. The reform aims to improve core health financing functions, revenue collection, pooling and strategic purchasing, while reducing the country's long-standing reliance on OOP health spending.

To lead this transformation, the Health Insurance Commission was established to design the scheme, define a national benefits package, develop provider contracting arrangements and set governance structures.

Early implementation includes the phased enrolment of government employees and subsidized coverage for vulnerable groups, alongside exploration of contracting with public and private providers. The reform

also seeks to shift from input-based budgeting to more strategic, output-based payment mechanisms. Complementary efforts focus on strengthening primary health care, expanding digital health systems and improving expenditure tracking.

Looking ahead, Iraq plans to extend coverage to private-sector and informal-sector workers while reinforcing governance, digital infrastructure and evidence-based health financing policies (9).

Jordan – Implementing a UHC and health financing reform plan

Jordan is implementing a Universal Health Coverage and Health Financing Reform Plan (2024–2025). The plan outlines a phased strategy to expand compulsory health insurance to all citizens and residents, beginning with primary health care. A key component is establishing a new insurance fund for uninsured Social Security Corporation members, forming the basis for gradually extending coverage nationwide. The plan aligns with the government's broader road map on UHC and aims to improve access to affordable, comprehensive services and strengthen overall system performance.

The reform addresses persistent structural challenges, including fragmented governance, reliance on exemptions and dependence on line-item budgeting. WHO's 2024 Health Financing Progress Matrix highlights these weaknesses and recommends gradual adoption of new payment mechanisms, such as global budgets and capitation, to enhance efficiency, cost control and pooling equity. Digitalization is also central, with nationwide computerization of hospitals and health centres underway to improve coordination and data quality.

Implementation begins with covering all public- and private-sector employees through a primary care-focused benefits package financed by a symbolic contribution of less than 1% of monthly salary. This foundational phase will enable broader population coverage, expanded benefits and a complementary role for voluntary private insurance (10–12).

Lebanon – Leveraging taxation and governance reform

Lebanon is working to restore its health financing system, which has severely deteriorated amid economic collapse, political instability and repeated crises. As one of the world's most OOP-dependent systems, it leaves households highly vulnerable. Public insurance mechanisms have nearly collapsed: the National Social Security Fund now covers only about 10% of medical costs, and more than half of the population lacks formal coverage. Essential medicine availability has fallen by around 50%, while fragmentation across public funds, private insurers, nongovernmental organizations and donors, combined with weak regulatory capacity, has undermined efficiency and accountability. Donor-dependent primary health care has also faced major disruptions, with more than 100 centres damaged or closed.

Despite this fragility, momentum towards UHC has revived. Lebanon has drafted multiple laws on UHC, most recently in 2024, and piloted performance- and capitation-based primary health care packages. A central reform proposal is health taxation: well-structured taxes on tobacco, alcohol and sugar-sweetened beverages could generate an estimated US\$ 789 million annually, though constitutional limits on earmarking, low excise rates, tax evasion and weak enforcement remain significant obstacles. Complementary initiatives, including pooled procurement of high-cost medicines and a new social health protection strategy, aim to strengthen financial protection and chart a sustainable path towards UHC (13).

Palestine – Striving towards financial protection amid protracted crises

Palestine is experiencing increased financial hardship from OOP health spending as families face occupation, conflict and deepening economic challenges. In this context, the Ministry of Health, supported by WHO and partners, is advancing reforms to strengthen financial protection and ensure more equitable access to essential health services.

Key priorities include routine monitoring of financial hardship, revision of the essential health services package and reform of the government health insurance scheme within an updated health financing strategy.

Financial hardship has been tracked since 2004, and recent analyses are guiding decisions on service entitlements and insurance redesign. Work is under way to define an essential benefits package that aligns with available fiscal space, identifies priority services and estimates per-capita and system-level costs to support implementation. Reforms to government health insurance focus on clarifying eligibility, adjusting co-payment policies and improving entitlements to enhance equity, affordability and overall system effectiveness (14, 15).

Pakistan – Expanding financial protection through the Sehat Sahulat Program

Pakistan is implementing a national health care initiative, now known as the Sehat Sahulat Program. This initiative originates from the Prime Minister’s National Health Programme, launched in 2015, and aims to provide cash-free inpatient care for low-income families through registered public and private hospitals. It initially targeted poor households identified through the Benazir Income Support Programme and the National Socio-Economic Registry, offering coverage for surgeries, maternity services, chronic conditions and emergency care.

The programme subsequently expanded across provinces, achieving nationwide rollout and full population coverage in Khyber Pakhtunkhwa by 2020, where the State Life Insurance Corporation purchases services from public and private providers, financing care up to 600 000 Pakistani rupees per family annually. The programme achieved universal population coverage in Punjab, but by 2024–2025 it faced sustainability challenges, as government budgets fully absorbed premium costs. This led to its recent relaunch, with revised design features to strengthen long-term viability.

Saudi Arabia – Applying innovative Islamic finance instruments

Saudi Arabia is implementing *takaful*, an innovative Islamic finance mechanism that strengthens health financing while aligning with Shariah principles and Vision 2030. *Takaful* operates on risk-sharing and mutual cooperation, offering an ethical alternative to conventional insurance. Tawuniya, the country’s largest insurer, operates as a *takaful* provider and plays a central role in delivering health coverage.¹² The mandatory health insurance requirement for expatriates introduced in 2024 significantly expanded demand for private health coverage, accelerating the growth of the *takaful* health insurance market. This model enhances financial protection by pooling contributions to cover members’ health expenses, reducing OOP payments and improving access to care. It also supports market competition, encourages private-sector participation and complements public health financing. By integrating *takaful* more deeply into the health system, through standardized benefits, digital platforms and regulatory oversight, Saudi Arabia can leverage Islamic finance to build an inclusive, sustainable and resilient health financing framework that responds to population needs while remaining Shariah-compliant.

Sudan – Piloting pooled procurement for high-cost, high-impact medicines

Sudan is progressing towards financial protection amid ongoing conflict through the 2023 introduction of pooled procurement for high-cost, high-impact medicines. With OOP spending exceeding 70% of total health expenditure and the national insurance scheme covering only a minority of the population, medicine prices had become a major driver of financial hardship for households.

The pooled procurement pilot consolidated purchasing for costly chronic-disease and cancer treatments, allowing the government to negotiate lower prices, reduce duplication and stabilize medicine supply. Its success generated a nationwide dialogue on institutionalizing pooled procurement as a long-term reform to strengthen efficiency and financial protection. By lowering medicine prices and improving availability,

¹² WHO Regional Office for the Eastern Mediterranean, unpublished internal report on leveraging Islamic financing for health, 2025.

the initiative reduced reliance on expensive private markets and protected families from unaffordable expenditures. The pilot also improved purchasing coherence by reducing fragmentation, strengthening centralized procurement and catalysing broader discussions on integrating pooled procurement into Sudan's national health financing architecture.

Tunisia – Advancing integration and equity through unified health insurance reform

Tunisia is advancing an ambitious health financing reform agenda under its National Health Policy to 2030, which was developed through an extensive societal dialogue process. It involves moving towards a unified social health insurance scheme to address the long-standing fragmentation between the compulsory National Health Insurance Fund (CNAM) for formal-sector workers and the free medical assistance programme (AMEN) for poor and vulnerable groups.

The reform would strengthen all health financing functions by improving contribution collection, introducing tax-based funding and modernizing CNAM. It would gradually integrate AMEN beneficiaries into a state-supported contributory model, consolidate fragmented schemes into a national pool and introduce strategic purchasing focused on primary care, family medicine, performance-based provider payments and equitable access to essential services.

More broadly, Tunisia seeks to transition from a hospital-centric model to a preventive, primary health care-led system to better address the rising burden of noncommunicable diseases and an ageing population (16–20).

United Arab Emirates – Delivering comprehensive health financing reform to align coverage and regulations

The United Arab Emirates has introduced nationwide health financing reforms that mandate employer-funded health insurance for all private-sector employees and domestic workers from 1 January 2025. This extends a system previously applied only in Abu Dhabi and Dubai to all seven emirates. Employers must purchase health insurance as a condition for issuing or renewing residency permits, strengthening revenue collection and expanding population coverage.

The federal Basic Health Insurance Scheme sets minimum benefit standards and co-payment rules, placing full premium responsibility on employers. This aims to improve financial protection for lower-income workers and promote more consistent coverage across the country.

Additional reforms enhance national coherence in purchasing and regulation through federal oversight of insurers, standardized benefit requirements and aligned compliance mechanisms across emirates. While these measures advance a unified national insurance framework, remaining differences in benefit structures and enforcement highlight the need for further harmonization to ensure equitable financial protection for all residents (21–24).

References¹³

1. The National Health Insurance Program (SEHATI) [website]. Manama: Supreme Council of Health of Bahrain; 2025 (<https://www.sch.org.bh/en/projects/the-national-health-insurance-program-sahti.html>).
2. Mandatory insurance for expats and visitors. The Daily Tribune – News of Bahrain; 29 March 2025 (<https://www.newsofbahrain.com/bahrain/110699.html>).
3. Mathauer I, Yehia KA, Mataria A. Implementing the universal health insurance law of Egypt: what are the key issues on strategic purchasing and its governance arrangements? Geneva: World Health Organization; 2019 (<https://iris.who.int/handle/10665/311781>). License: CC BY-NC-SA 3.0 IGO.
4. Khalifa AY, Jabbour JY, Mataria A, Bakr M, Farid M, Mathauer I. Purchasing health services under Egypt's new universal health insurance law: what are the implications for universal health coverage? Int J Health Plann Manage. 2022;37:619–31 (<https://doi.org/10.1002/hpm.3354>).
5. Global Health Expenditure Database: Egypt country profile [online database]. Geneva: World Health Organization (https://apps.who.int/nha/database/country_profile/Index/en).
6. Hammad AS, Khalifa AY, ELKarim GG, Mataria A, Fouad AM. Effect of universal health insurance implementation on beneficiaries' evaluation of public health facilities in Egypt – a cross-sectional study. Int J Equity Health. 2025;24:59 (<https://doi.org/10.1186/s12939-025-02402-9>).
7. Hetta R. Implementing universal health insurance: case study of stakeholders' perspectives in Port Said, Egypt [thesis]. Cairo: The American University in Cairo; 2023 (<https://fount.aucegypt.edu/etds/2209/>).
8. Egypt national health accounts: establishing an expenditure baseline to support Egypt's health care reform 2019/2020. Cairo: WHO Regional Office for the Eastern Mediterranean; 2023 (<https://p4h.world/en/documents/egypt-national-health-accounts-2019-2020/>). Licence: CC BY-NC-SA 3.0 IGO.
9. Health Insurance Law No. 22 (2020). Baghdad: Government of Iraq; 2020.
10. Health financing progress matrix assessment, Jordan 2024: summary of findings and recommendations. Cairo: WHO Regional Office for the Eastern Mediterranean; 2024 (<https://iris.who.int/handle/10665/379932>). Licence: CC BY-NC-SA 3.0 IGO.
11. Hafez R, Ziway R, Serfontein N. A sustainable path to UHC: assessment of Jordan's government and public insurance schemes. Washington, DC: World Bank; 2024.
12. Carroll N, Bloch C, González-Pier E, Kiss S. Jordan health spending efficiency: issues and reform directions. Washington, DC: International Monetary Fund; 2024 (<https://doi.org/10.5089/9798400264610.029>).
13. Abou Samra C, Assal M, El-Jardali F. Financing universal health coverage in Lebanon through health taxes. Beirut: Knowledge to Policy (K2P) Center; 2023 (<http://hdl.handle.net/10938/34821>).
14. World Health Organization & International Bank for Reconstruction and Development/The World Bank. Tracking universal health coverage: 2025 global monitoring report. Geneva: World Health Organization; 2025 (<https://iris.who.int/handle/10665/384883>). Licence: CC BY-NC-SA 3.0 IGO.
15. Palestine economic update, February 2026. Ramallah: Palestine Economic Policy Research Institute (MAS); 2026 (<https://mas.ps/en/publications/13676.html>).
16. Politique nationale de santé (PNS) 2030 [National health policy 2030]. Tunis: Ministry of Health; 2021.
17. Livre blanc: pour une meilleure santé en Tunisie, faisons le chemin ensemble [White paper: for better health in Tunisia, let's walk the path together]. Tunis; Dialogue Sociétal; 2014.
18. Tunisia national health accounts 2022: preliminary findings [internal document]. Tunis; December 2024
19. Enquête nationale sur le budget, la consommation et le niveau de vie des ménages 2021 [National survey on household budget, consumption and standard of living]. Tunis: National Institute of

¹³ All references were accessed on 7 September 2026.

- Statistics; 2023 (<https://www.ins.tn/enquetes/enquete-nationale-sur-le-budget-la-consommation-et-le-niveau-de-vie-des-menages-2021>).
20. Enquête nationale sur la population et l'emploi, 2019/2020 [National survey on population and employment]. Tunis: National Institute of Statistics; 2020.
 21. The basic health insurance scheme [website]. Ministry of Human Resources and Emiratisation, United Arab Emirates (<https://www.mohre.gov.ae/en/guidance-and-awareness-portal-new/the-basic-health-insurance-scheme>).
 22. UAE healthcare and insurance reforms for employers and insurers [website]. Mouannes International Specialized Legal Consultants; 2025 (<https://misconsultants.ae/article/uae-healthcare-and-insurance-reforms-for-employers-and-insurers>).
 23. UAE Federal Budget [website]. United Arab Emirates Government (<https://mof.gov.ae/en/public-finance/uae-federal-budget/>).
 24. Health accounts system of Dubai 2022 [website]. Dubai Health Authority; 2022 (<https://www.isahd.ae/Home/Reports>).