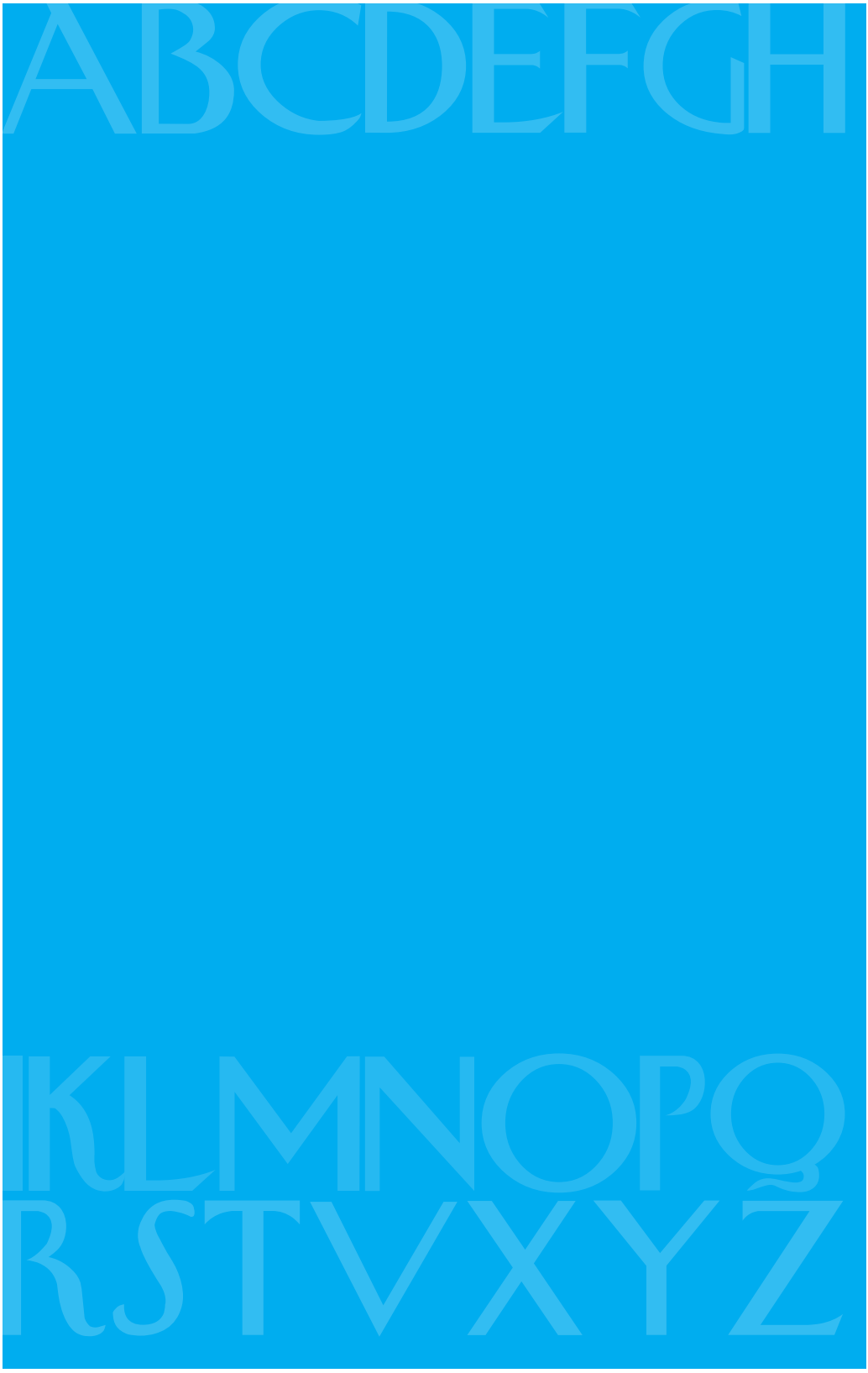
The Country Edition

unicef
for every child

For sustainable health investments in children

HEALTH ECONOMISTS NETWORK

From A to Z


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The Country Edition

For sustainable health investments in children

HEALTH ECONOMISTS NETWORK

From A to Z



Global Health Practice | Health Economics and Financing



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Foreword

There is broad agreement on the importance of financing children's health. Turning that agreement into a budget line has proved more difficult, despite real progress.

The evidence shows the scale of the challenge. In 2023, one of 54 African countries was at or above the Abuja Declaration benchmark of allocating 15 per cent of government spending to health, and on historical trends 42 of 51 countries are off track to reach it by 2063.[1] As external financing contracts, decisions on child health are increasingly settled in domestic budget processes, where the arguments are fiscal.

One reason agreement stalls at the budget stage is the absence of timely evidence: analysis produced by people who understand the context, who are present when the decision is taken, and who can explain the numbers to those who take it. That capacity is often missing where the decision is made.

UNICEF has worked on the financing of children's health services for a long time. The Health Economists Network builds on that work. Funded from UNICEF's own resources, it places nationally recruited health economists inside government in twenty countries, for four years each.

Placing advisers in ministries is an established practice, and we have learned from the organizations that have done it before us. What the Network brings together is national recruitment, a four-year duration and a founding cohort of twenty countries working in parallel, with children as the explicit focus of the analysis. For any partner that wishes to support countries through the transition from external to domestic financing, the Network is designed to be a practical instrument.

This booklet is a short introduction. It has twenty-six entries, one per letter, covering what the Network is, where it came from and what the health economists do. The programme document and the fuller technical material are available to readers who wish to engage further with the programme, and I encourage you to read them.

Readers with limited time will find the essentials in entries A to D.

Dr Helga Fogstad
Director, Global Health Practice
UNICEF Centre of Excellence for Child Survival and Development
Global Programme Division, UNICEF

1 Beyond aspiration: an expenditure-based evaluation of progress towards the Abuja Declaration target and implications for domestic health financing in Africa. PLOS Global Public Health, forthcoming.

The Health Economists Network, from A to Z

Twenty-six entries, one for each letter.

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A to D

The programme in brief

What the Network is, whom it serves, how long it runs and where the health economist works.

A **Ambition.** What the Network is, and why now

The Health Economists Network is a UNICEF programme that places a nationally recruited health economist to work full time, for four years, inside government entities such as the ministries of finance, health and planning. It gives governments dedicated health economics expertise, so that those who hold the budget have the analysis they need at the moment they need it.

Three developments make this timely. Official development assistance is contracting. Transitions from the global institutions that finance vertical programmes are accelerating, shifting costs onto national budgets, often faster than those budgets can absorb them. And debt service is putting pressure on health allocations in many of the participating countries.

Taken together, these developments have moved health financing towards the centre of country strategy. Decisions on child health are increasingly settled in domestic budget processes, where the arguments are fiscal. Ministries that can cost their plans, show the consequences of underfunding and demonstrate efficiency are better placed to protect resources for children.

UNICEF has produced health financing analyses for decades, through short-term consultancies and academic partners. What is new is the placement: the economist works inside the ministry, full time, for four years.

B **Beneficiaries.** Whom the Network serves

Governments are the first beneficiaries. The Network is not a new UNICEF country office staffing plan. The health economist works inside a government entity, on a workplan set by the host government, and the expertise is the government's to direct.

Ministries already carry this work, often with small teams and long agendas, and at times with the support of partners. The Network adds capacity alongside them, on their calendar. Success will be measured on their side: a budget line that holds, a benefit package that keeps children inside it, a transition plan that the ministry of finance owns.

Children are the beneficiaries at the end of that chain, which is why UNICEF has taken this on. They are reached through the government's decisions.

One caution applies. A placement improves the quality of the argument and brings the analysis into the discussion while the decision is still open. It does not guarantee that the budget will rise. That decision remains with the budget holder.

C **Commitment.** Design, duration and evaluation

The Network was designed by the Health Economics and Financing Section of UNICEF. The twenty countries listed at letter T form the founding cohort, and each placement runs for four years.

The intention is to continue beyond the first cycle, for as long as ministries need health economists and children's health budgets need to be argued for. Independent evaluation, during and at the end of the cycle, will assess whether the approach has delivered, and its findings will inform what follows.

Country offices finance years three and four of each placement, which signals that the office considers the work worth sustaining. The intended destination of each post is the government's own payroll. The programme is also open to any funder with an interest in mothers' and children's health (see letter V).

D **Desk.** Where the health economist works

The health economist works full time inside government, moving between the budget office, the financing directorate, the planning unit and other offices as the work requires. Being present every day gives access to the working discussions in which questions are first framed, and which short missions rarely reach. Each placement is also anchored to a set of decisions.

This is the main difference from a consultancy. A consultant usually arrives once the question has been framed and leaves when it has been answered. A health economist in the Network is present earlier, while a director is still deciding which question to ask, and is still there months later when the answer has to be defended in a budget hearing.

E to I

The starting point

What UNICEF already does, what the 2025 survey found, the gap that donor transitions leave, and the risks to manage.

E **Established.** What UNICEF already does in health economics and financing

UNICEF has worked in this field for decades: costing exercises, fiscal space analyses, investment cases and budget briefs, across immunization, maternal and newborn health, community health and primary health care. Many of these have shaped national decisions. A good deal of the work has been carried by country offices and regional offices.

Two factors have limited it, and neither concerns the quality of the work. The first is that the work has been commissioned and not continuous. An analysis is requested, a consultant is hired, a report is delivered, and the capability leaves with its author. The next question, six months later, starts again from the beginning.

The second is coverage. Not every country office has a full-time economist to lead this work.

What the Network brings is continuity. There is a named person, inside the ministry, for four years, whose role this is. A question raised today can be answered within weeks by someone who already knows the budget calendar and took part in the earlier discussion.

In other words, the Network does not mark the start of UNICEF's engagement in health economics. It gives that engagement a stable place and a clear mandate inside government.

F Foothold. Findings of the 2025 global survey

In November 2025, the Health Economics and Financing Section surveyed 121 colleagues from 55 country, regional and headquarters offices on their involvement in, and use of, health economics work. The survey was conducted in English, French, Spanish and Portuguese. Six findings stand out.

- **The work exists, and it varies.** Sixty-four per cent of offices had carried out at least one health economic analysis in the previous five years.
- **Dedicated expertise is scarce.** In just over a quarter of offices, no colleague was working specifically on health economics and financing. Six per cent had a health financing specialist. The others relied on consultants.
- **Analysis travelled furthest when it was close to a decision.** Costing performed best, with 49 per cent of offices reporting that it had informed a government or partner decision. Fiscal space and cost-effectiveness analyses reached around 35 per cent.
- **Child-focused analysis offers the widest opening.** Sixteen per cent reported that equity or distributional analysis had informed a decision, and 64 per cent had not yet produced one.
- **The obstacles are known.** Limited funding; staff turnover, with the analysis leaving when its author does; limited institutional memory; reliance on short consultancies; and limited coordination across sections.
- **Colleagues were clear about priorities.** Costing and budgeting first, then sustainability and domestic resource mobilization, then efficiency. This order is broadly reflected in the areas of work at letter Q.

Taken together, the findings describe a problem of continuity. The demand exists, the skills exist in parts of the organization, and analyses have been produced intermittently, as funding and staff time allowed.

G Gap. What donor transitions leave behind

External financing for health is contracting, and several funders are moving at the same time: bilateral programmes, Gavi, the Global Fund and others. Each transition transfers costs to national budgets. When several arrive together, the combined bill can exceed what a budget is able to absorb in the time allowed, and the services at risk include those that reach children.

Domestic budgets are not yet closing that gap. On historical trends, 42 of 51 African countries are off track to reach the Abuja Declaration benchmark of 15 per cent of government spending on health by 2063. Among countries that have never reached it, the median probability of doing so is about 8 per cent.[2]

The gap is therefore not only financial. It is also a gap in the analysis a government needs to manage a transition: which programmes are exposed, what the shortfall will be and when, and how the cost can be absorbed year by year.

This is where the Network works. A health economist inside government can cost the transition, model its consequences for children and help carry the plan into the budget (see Q3). For a funder, supporting a placement helps to protect what earlier investments built.

2 Beyond aspiration: an expenditure-based evaluation of progress towards the Abuja Declaration target and implications for domestic health financing in Africa. PLOS Global Public Health, forthcoming.

H Hazards. Risks, and how the design addresses them

Four risks are recognized, and each has a response built into the design.

- **Political turnover and macroeconomic pressure.** A minister changes or a currency weakens, and the analysis waits. The four-year presence is the response.
- **The health economist gradually becomes a general analyst.** This is the most likely risk. The response is a protected mandate in the terms of reference, a quarterly technical review, and a route to escalate if it begins to happen.
- **The capacity leaves at the end of the cycle.** The response is country office financing for years three and four, an alumni network, and a design intended for national institutions to absorb the post.
- **Recruitment takes longer than planned.** The specialist market is thin. The response is a competitive open call through national and regional academic institutions.

Each of these is a known risk in embedded placement programmes.

Intentionality. Why children need an explicit place in the analyses

Standard practice optimizes around the average patient. A benefit package designed for the average patient funds what that patient needs, and the average patient does not need a paediatric formulation, a growth chart or a vaccination schedule.

This is not a separate discipline. It is a matter of intentionality: ensuring that the analysis for children is carried out explicitly, because it is seldom produced by default.

J to P

Design choices

Why UNICEF, what earlier programmes show, what stands behind each placement, and how it complements other partners.

J **Justification. Why UNICEF**

UNICEF combines four things that are seldom found in the same organization.

- A permanent presence in the country, as opposed to a project office with a fixed end date.
- An existing technical relationship with several ministries, from health and finance to education, planning, statistics and social affairs, which gives a rounded view of children's needs.
- Specifically, a route into the ministry of finance. In most countries, this runs through colleagues working on public finance for children, who hold the knowledge of the budget cycle and the relationships across the social sectors. The health economist brings the health sector depth.
- A mandate that makes children the explicit unit of analysis, and not a subset of an average population.

The first three provide access. The fourth changes the output. The work is the government's to direct; what UNICEF adds is one question: whose coverage is defended when a benefit package is trimmed.

K **Kindred. Programmes consulted in the design**

Placing economists alongside governments is an established practice going back to the 1960s. In designing the Network, UNICEF studied several long-running programmes, among them the ODI Fellowship Scheme and the World Bank Early Years Fellowship.

These are well-regarded programmes, several of them run by partners of UNICEF, and the Network owes part of its design to them. The lessons drawn are set out at letter L. They concern the model and its outcomes in general, and not any particular programme.

The Network differs from a fellowship in one respect. It recruits experienced professionals, who are expected to contribute at a senior level from the start, with the support of the UNICEF Centre of Excellence and a network of more than 25 university departments.

L Lessons. What earlier programmes show

Four lessons recur.

- Demand-led placements work better than supply-led ones, so the workplan follows the ministry's agenda.
- Continuity matters more than intensity, because influence builds gradually.
- A cohort works better than a single placement, because the same problems recur across countries and peers can share what they have learned.
- Technical backing for the individual improves the quality of what is produced.

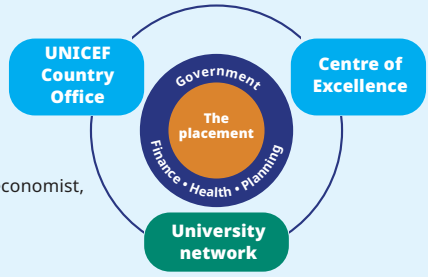
Each of these became a design choice, described in the entries that follow.

M Machinery. What stands behind each placement

The Network does more than place a person in a ministry. Each health economist works within a structure built to support the work for four years.

The UNICEF country office
A standing link to the country programme.

The government
Sets the workplan, hosts the economist, and owns what is produced.



The Centre of Excellence
Common methods, technical support on request, and the cohort of twenty peers.

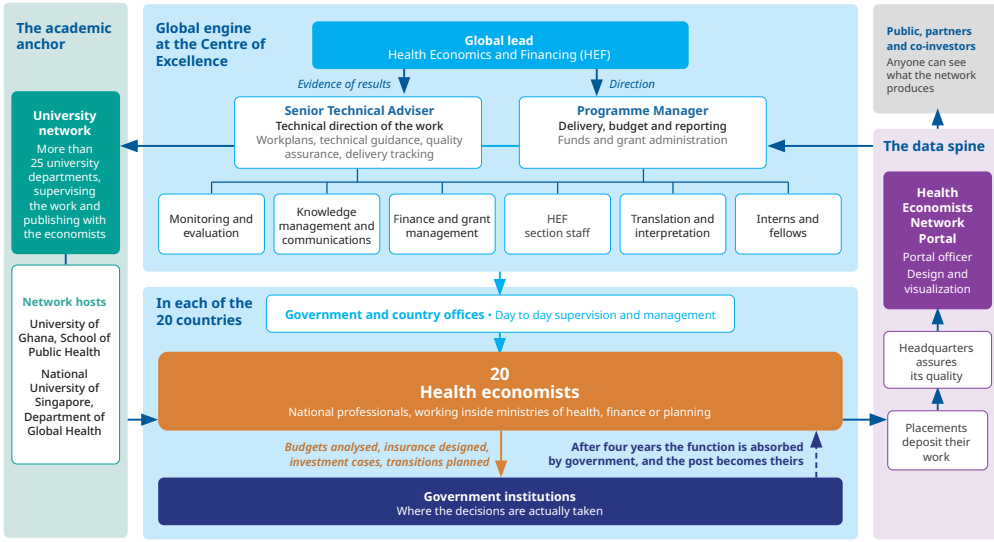
The university network
Academic supervision, shared methods and co-authorship, across more than 25 departments.

- **The government** sets the workplan, hosts the economist and owns what is produced.
- **The UNICEF country office** provides a standing link to the country programme.
- **The Centre of Excellence** provides common methods, technical support on request and the cohort of twenty peers.
- **The university network** provides academic supervision, shared methods and co-authorship, across more than 25 departments.

Behind these sit the portal that holds the Network's work and the functions at the Centre of Excellence that keep the programme running. The diagram on the next page shows how the parts connect: the role of government, the functions at the Centre of Excellence, the portal, the arrangement in each country and the university network.

The Health Economists Network: How it runs

UNICEF places nationally recruited health economists inside government institutions in 20 countries, four years each, from 1 October 2026.



National. Why national recruitment, and why four years

The Network places a trained health economist, or an economist specialized in the health sector, recruited competitively at national level. Qualified candidates exist: in ministries, central banks and universities, and among nationals working abroad who may consider returning for a role with this level of access. Where the pool is smaller, recruitment will take longer.

National recruitment determines what remains after the placement. The expertise stays in the country and remains available to national institutions. This does not diminish international expertise, which has its place, nor exchange between countries, which is built into the design.

The duration matters as much. Influence builds over time, from learning who decides what and when, to being consulted before a decision is taken. Four years corresponds to a national budget cycle and to the grant cycle of many international institutions.

O **Overlap.** How this placement scheme complements other partners

Health financing is a field with many long-standing actors. The World Bank and the Global Financing Facility support reforms and investment operations. WHO sets norms and tracks progress. Gavi and the Global Fund manage vertical financing, each with its own transition and co-financing policies. The field has also widened: long-established and newer philanthropies, and regional development banks, are increasingly active in financing health.

So what does a further UNICEF initiative add? It is a fair question.

The Network does not create a parallel agenda. The health economist works for the government, on the government's workplan, and the analysis is available to the government in all its discussions with partners. A costing prepared for a budget submission can also serve an investment case, a transition plan or a co-financing commitment.

The contribution is specific in two ways. The placement is national and lasts four years, so the capacity stays inside the institution when individual projects end. And the analysis makes children explicit, where standard analysis often treats them as part of the general population.

Where development banks prepare operations in the host country, the same analysis can help to build child-focused economics in at the design stage.

P **Platform.** The HEN Portal

Twenty health economists working inside twenty governments will produce a large body of work over four years. The HEN Portal is the platform that brings this work together, so that the whole Network can see it, question it and reuse it. Placements deposit their work, the Centre of Excellence assures its quality, and the public can read what the Network produces. The university network supports the placements with evidence generation, cross-country analysis and technical assistance matched to their needs.

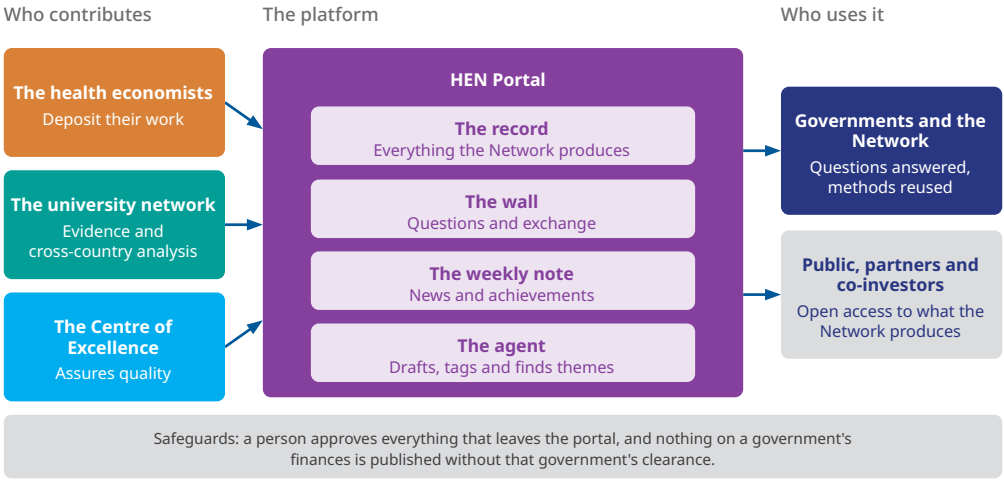
The portal has four parts.

- **The record.** Deliverables, methods, results and documented successes are held in one searchable place, with a page for each country.
- **The wall.** A space where members of the Network post questions and updates, so that a problem solved in one country is available to the others. It is open to the placements, country offices, universities and government counterparts, and not to the public.
- **The weekly note.** A short update carrying country news and the main achievements of the week, shared across the Network.
- **The agent.** An automated assistant that drafts the weekly note, tags what is deposited, answers questions put to the portal and groups recurring questions into themes. It takes no decisions.

Two safeguards apply. A person reviews and approves everything that leaves the portal, and nothing concerning a government's finances is published without that government's clearance.

The questions received also guide the Network's analytical agenda. When the same question arrives from several countries, it points to a need for thought leadership: a method worth documenting, a paper worth writing or a course worth teaching. The university network takes it forward.

The HEN Portal: what goes in, and who uses it



The portal is a global public good. It is what a partner supports when it chooses to power the platform (see letter V).

Q to S

The work and its standards

The areas of work, the reforms that frame them, and how the quality of the analysis is assured.

Questions. The areas of work

The range of work is wider than the two requests most often made in health financing discussions: a costing, and an innovative financing option. Both are useful, and both are covered here. Costing is one entry among more than forty, and innovative financing is one list among eight. The remainder is the work that determines whether a budget line holds: fiscal space, expenditure review, provider payment, benefit package design, transition planning, actuarial modelling, equity analysis and outbreak costing.

The lists are indicative and not exhaustive, and they are not a form to complete. They show a host government the range of options, and they support a conversation that starts from the problem to be solved. Governments often open with a request for a specific analysis. It is usually more productive to begin with the decision that is coming, who needs to be persuaded and by when. The framing of the question and the choice of analysis follow from there.

A budget submission in preparation points to Q1 and Q4. A Gavi transition points to Q3. A benefit package under revision points to Q5 and Q7. An outbreak, or a Pandemic Fund application, points to Q8. Most placements will move across several areas over four years, and each workplan can include any other health economics and financing topic chosen by the host government.

Eight example areas are set out below. They do not limit the actual work.

Q1 Health financing strategy and domestic resource mobilization

Types of analysis	What it delivers
National health financing strategy and reform design	A multi-year roadmap combining domestic resources, transition planning and new mechanisms, with comparative analysis of tax-funded, insurance-based and hybrid models.
Fiscal space analysis	Whether the government can afford to spend more on health, and through which route: growth, revenue, reallocation, borrowing or efficiency.
Public expenditure review for health	Where the health money actually goes, how much reaches service delivery, and where it is lost between allocation and execution.
Costing of national strategies and investment cases	Turns policy commitments into budget requirements, quantifies the gap, and builds the argument that unlocks financing.
Domestic revenue options for health	Which existing revenue streams could carry more health spending, and what each would take politically.
Financing governance and accountability	Oversight of health funds: tracking, transparency and safeguards. Bridges emergency financing with long-term systems in fragile settings.

Q2 Price norms and regulation

Types of analysis	What it delivers
Unit cost analysis for priority services	Cost benchmarks for facility delivery, vaccination, outpatient and non-communicable disease care, so budgets reflect what delivery actually costs.
Pharmaceutical price benchmarking	Compares national prices with regional and international norms, and identifies room for negotiation or pooled procurement.
Provider payment design	Capitation, case-based payment, performance-based financing, and how each shapes the incentives providers respond to.
Health technology assessment	Whether a new medicine, vaccine or technology is worth its cost, before it enters the benefit package.
Community health worker costing	What it costs to compensate community health workers sustainably, and where that money can come from.
Efficiency analysis	Where the same money could buy more, and what stands in the way of moving it there.

Q3 Donor transition planning and sustainable financing

Types of analysis	What it delivers
Transition risk and financing gap analysis	Which programmes are exposed, how much funding is at risk, and the shortfall when external support ends.
Post-transition impact modelling	What follows if the gap is not filled, expressed in coverage and outcomes rather than percentages.
Scenario and cumulative impact modelling	Full, partial and delayed transition, and the combined effect when several funders move at once.
Transition roadmap and operationalization	A year-by-year absorption plan with revenue sources, budget allocations and quarterly milestones with named responsibilities.
Co-financing compliance analysis	Whether the government can meet its co-financing obligations on schedule, and what happens to eligibility if it cannot.
Absorption capacity assessment	Whether the systems that would receive the transferred functions can actually run them, and what it costs to prepare them.

Q4 Health economic analysis and child-focused equity

Types of analysis	What it delivers
Benefit incidence analysis	Where public health spending lands across wealth quintiles and geographies, and how much reaches children in the poorest households.
Extended cost-effectiveness analysis	Health gains, financial protection, and the distribution of both. Answers not only whether an intervention is good value, but for whom.
Distributional cost-effectiveness and equity weighting	Makes the equity and efficiency trade-off explicit while a benefit package is being designed, and tests how the ranking changes when equity is given weight.
Inequality measurement and decomposition	Concentration indices and decomposition methods: how unequal coverage is, what drives it, and whether the gap is narrowing or widening.
Financial protection for households with children	Catastrophic and impoverishing health spending, disaggregated for families with young children.
Costing of reaching zero-dose and missed communities	What it costs to reach children currently receiving no services, which runs higher than the average and is often absent from budget assumptions. Includes the cost of inaction.

Q5 Primary health care and essential benefit package

Types of analysis	What it delivers
Benefit package definition and prioritization	Which services are included, based on disease burden, cost-effectiveness and equity, with child and maternal services prioritized explicitly.
Primary health care package costing	What the full package costs to deliver, including antenatal care, and where the gap sits.
Primary health care investment case	The economic argument for scaling primary care: returns, lives, and hospital costs avoided.
Service delivery level costing	Community, health centre, first-level hospital and referral, so efficiency gains can be located where they sit.
Sustainability modelling	Long-term costs under demographic change, epidemiological transition and new technology.
Translation for policymakers	Costing studies and fiscal space analyses turned into two pages a minister can act on.

Q6 Innovative financing options

Types of analysis	What it delivers
Health taxation options	Tobacco, alcohol, sugar-sweetened beverages, carbon. Revenue potential and health co-benefits assessed together.
Diaspora bonds and remittance mobilization	Channelling diaspora contributions and remittances into health infrastructure or insurance subsidies.
Blended finance and public-private structuring	Grants alongside private capital to de-risk cold chains and local manufacturing, with risk allocation that protects public interests.
Climate and pandemic fund access	Positioning health investments within climate resilience and pandemic preparedness financing windows.
Results-based instruments	Social impact bonds and payment-for-results contracts that bring private capital to programmes with measurable outcomes.
Debt-for-health swaps and subnational mechanisms	Debt relief linked to health spending commitments, and local revenue generation for community health platforms.

Q7 Health insurance options and design

Types of analysis	What it delivers
Feasibility and options analysis	Tax-funded, contributory or hybrid. Fiscal sustainability, political economy, and what each model would demand of the system.
Benefit package design for insurance	What the scheme covers, and whether children sit securely inside the package or at its edges.
Premium setting, subsidies and targeting	Contributions for formal sector workers, subsidies for those who cannot contribute, and identification systems that reach the poorest households.
Actuarial and financial sustainability modelling	Whether the scheme's revenues can meet its liabilities over time, under realistic enrolment and utilization assumptions.
Governance and accountability frameworks	Oversight that protects the scheme's finances and builds enough public confidence for people to enrol.
Transition pathways to universal coverage	Bringing separate schemes for civil servants, informal workers and donor programmes into a coherent system.

Q8 Economics of emergencies and health security

Types of analysis	What it delivers
Costing of outbreak preparedness and response	What a response costs by function, from surveillance and laboratory capacity to case management and community engagement, so surge budgets rest on unit costs.
Support to Pandemic Fund and health security applications	Builds the costed proposal and the domestic co-investment plan these mechanisms require.
Community health worker financing during and after outbreaks	Who pays surge workers, at what rate, and what happens when the emergency line closes.
Emergency to development financing transition	How a function financed through a humanitarian appeal moves onto a national budget line, and what it costs to keep it there.
The economic case for preparedness	The cost of preparing set against the cost of responding, in terms a ministry of finance recognizes.
Fiscal shock analysis for child health	What happens to child health allocations when a crisis reallocates public spending, and which lines are most exposed.

R **Reforms.** The Network in a changing global health architecture

The way global health is organized and financed is under review. In May 2026 the World Health Assembly launched a one-year, Member State-led process to reform the global health architecture, with the stated aim of aligning financing "to advance national self-reliance". The Lusaka Agenda, the Sevilla Commitment on financing for development and the Accra Reset point in the same direction: country leadership, domestic resources as the foundation, and external funding that supports national systems.

These reforms share a practical requirement. A government that is expected to lead needs the capacity to cost its plans, set priorities, negotiate with its ministry of finance and its partners, and manage the move from external to domestic funding. Where that capacity is thin, country leadership remains more a principle than a practice.

The Network is one concrete contribution to closing that distance. It places analytical capacity inside government, for four years, under the government's direction. As the reform processes report and their recommendations reach countries, the health economists will be positioned to help governments act on them.

S **Standards.** How the quality of the analysis is assured

Analysis that informs a national budget has to withstand scrutiny from the ministry of finance, from partners and from peers. The Network rests that assurance on academic institutions, and not on UNICEF alone.

A network of more than 25 university departments supervises the work and publishes with the health economists. It is being built with two host institutions: the University of Ghana, School of Public Health, and the National University of Singapore.

The universities contribute in three ways.

- **Shared methods.** Common approaches to costing, fiscal space, equity and other analyses, so that work in one country is comparable with work in another and consistent with the methods used across the health financing field.
- **Academic supervision.** Each health economist receives academic supervision while the work is under way, alongside technical support from the Centre of Excellence.
- **Co-authorship and publication.** Analyses are written up with university partners and submitted to peer-reviewed journals, which opens them to independent review.

The government decides how its analysis is used. The universities help to make sure that what it uses is sound.

T to V

The founding cohort and its partners

The twenty countries, the university links, and how partners can invest.

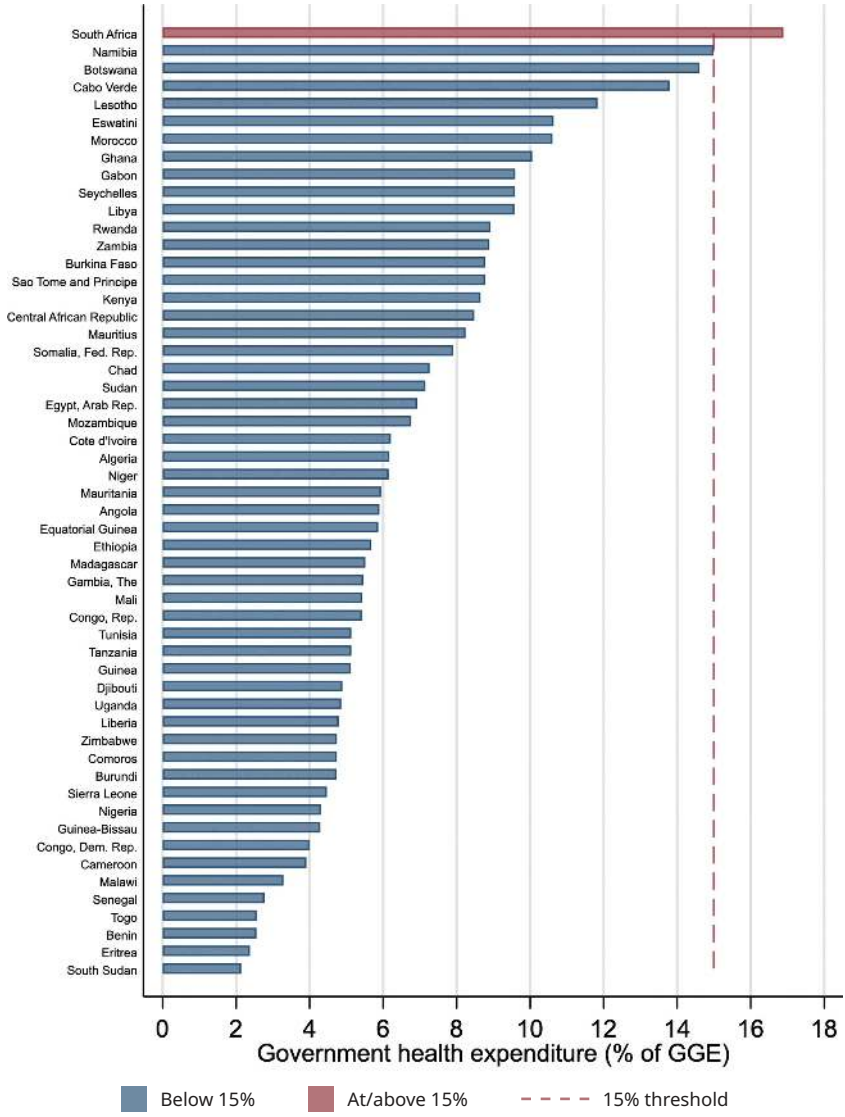
T — Twenty countries. The founding cohort and how it was selected

The founding cohort has twenty countries.



Selection weighed four considerations: exposure to reductions in external financing, such as a severe or immediate withdrawal of foreign aid or several donor transitions at the same time; the momentum behind ongoing reform; the policy context, meaning a government request and a reform or budget decision within reach, such as a health financing strategy, an insurance reform or a transition plan; and the scale of child health and equity need.

Eleven of the twenty countries are in Africa. In 2023, one of 54 African countries was at or above the Abuja Declaration benchmark of 15 per cent of government spending on health, and on historical trends 42 of 51 are off track to reach it by 2063. The figure that follows shows the position in 2023. Changing that depends on analytical capacity inside the ministries where those budgets are set.



Government health expenditure as a percentage of general government expenditure, African countries, 2023.[3]

Countries outside the founding cohort are addressed at letter V.

3 Beyond aspiration: an expenditure-based evaluation of progress towards the Abuja Declaration target and implications for domestic health financing in Africa. PLOS Global Public Health, forthcoming.

U **University links.** Building the next generation of health economists

The universities do more than assure quality (see letter S). They are also where the next health economists are trained. Health economics is taught in relatively few places, which is part of the reason the pool of specialists is small.

Each placement is therefore linked to a university in its own country: one department, one working relationship. The health economist may teach on a health financing course, supervise a student or bring live policy questions into the classroom. Many officials in the host ministries studied in these same faculties, so the link also strengthens the relationship with government.

For the health economists themselves, the placement offers a career path that is uncommon in this field.

- **Responsibility.** Working inside a ministry on decisions that shape national budgets.
- **A cohort.** Nineteen colleagues across six regions, with regular exchange between them.
- **Visibility.** Publication under their own name, with the support of university partners.
- **A lasting network.** An alumni network connecting them to each other and to regional and international health economics associations.
- **The option to mentor.** Pairing with an early-career colleague, recognized as part of the role.

If a government recruits the health economist at the end of the placement, the programme has achieved its purpose.

V **Venture.** How partners can invest

UNICEF went first: the founding cohort is fully funded. A partner joining now extends a programme that is already financed, and chooses where it grows. The unit of investment is one placement.

- **Deepen.** A second economist where the need and the policy window are greatest.
- **Broaden.** Countries beyond the founding twenty, including a second cohort.
- **Sharpen.** A cohort defined by theme, specialism or profile, for example women health economists.
- **Power the platform.** The portal, the technical coordination and the partner universities, which serve as global public goods (see letter P).

Contributions can be co-branded and phased across financial years. The investors' edition gives the detail, and figures are available from hef@unicef.org.

W to Y

From diagnosis to return

Working across government, a shared diagnosis of transitions, and what the investment returns.

W — Whole of government. Working across ministries and sectors

The financing of children's health is not decided in the ministry of health alone. The budget ceiling is set by the ministry of finance and the investment plan by the ministry of planning. In many countries, insurance subsidies for poor households sit with the ministry responsible for social protection. Outcomes for children also depend on spending on nutrition, water and sanitation, and education.

The health economist is therefore placed where the question sits, in the ministry of health, finance or planning, and works across them. Where a financing question extends into another sector, the economist works alongside the financing specialists of that ministry. The mandate stays on health economics and financing, so that specialist work is not displaced by general tasks.

UNICEF's own work shows how far these questions reach. The Child Nutrition Fund encourages governments to invest their own resources in nutrition services and supplies. The Supply Division's financing instruments, such as the Vaccine Independence Initiative, pre-finance essential supplies so that governments can procure them before budget funds are released. Work on assistive products for children with disabilities, such as wheelchairs and hearing aids, raises the question of who pays for items that are often absent from benefit packages. A health economist inside government can connect each of these to the national budget.

For partners, this is where the Network can be most useful: an analyst with access to both the health side and the finance side of government, able to bring the two to the same figures.

Administrative arrangements are simple. The UNICEF country office recruits the health economist and holds the contract, with technical support from the Centre of Excellence.

X **X-ray. One picture of all the transitions a country faces**

Each funder plans its transition from its own perspective: its own portfolio, its own timetable and its own co-financing rules. Seen one at a time, each plan may look manageable. A government faces all of them together, and so do children, whose services depend on several funders at once. That whole picture is seldom assembled in one place. This is the gap described at letter G.

UNICEF is not a donor managing its own exit. As a partner to government, it expects each placement to help fill that gap, starting with a diagnosis carried out with the host government during the first months.

The diagnosis answers four questions.

- **Where does the money come from?** The sources of financing for children's health: the national budget, insurance, households and external partners.
- **What is changing?** Which funders are reducing or ending their support, over what period, and what the combined effect is on services for children.
- **Who decides, and when?** The budget calendar, and the points at which the ministries of finance, health and planning take their decisions.
- **What is already known?** The analysis the government already holds, from all partners, and where evidence is missing.

The result is a single view of the transitions the country faces, owned by the government and available to all its partners. It leads to the choice of a first decision to support, and to a workplan set by the host government.

From then on, the programme tracks one thing above all: whether analysis is used in government decisions. The measure is a budget, a benefit package or a transition plan informed by the work, and not the number of products delivered.

Y **Yield.** What the investment returns

No programme can state its return before it has results, and the Network does not claim one. What can be stated is what comparable investments have returned.

- **Analytical capacity inside government can repay its cost many times over when its advice is used.** An assessment of India's health technology assessment body estimated a return of 9 to 1 on its annual cost, from three studies whose recommendations were implemented.
- **Long-term, embedded support has the stronger record.** An independent evaluation of the ODI Fellowship Scheme found that fellows filled skills gaps and contributed to policy in their host ministries. A wider review found little cumulative impact from repeated short-term assistance.
- **Capacity takes time.** A study of 115 countries found that technical assistance increased tax revenue, with the effect building over the long run.

The same evidence carries a warning: support that substitutes for national staff can erode the capacity it is meant to build. The Network's design responds with national recruitment, a place inside government and a four-year duration.

For a funder, the reasoning is simple. A placement is a small cost set against the budgets it informs. If the analysis moves even a small share of a national health budget towards services that reach children, or prevents a gap when a funder leaves, the return is a multiple of the outlay. The Network will document those cases as they occur. The studies cited are listed in Notes and sources.

Z

The closing argument

Why financing children's health is not a trade-off.

Z Zero-sum. Why financing children's health is not a trade-off

In a tight budget, every allocation looks like a loss for something else. A ministry of finance weighing health against roads, energy or debt service is making that calculation, and children's services are often treated as a cost within it.

The Network starts from a different reading. Much of the gain for children does not require new money. It comes from spending existing resources better: fewer funds lost between allocation and execution, prices that are benchmarked, benefit packages that buy what works, and transitions planned before the gap opens. Where new money is needed, spending on children's health is an investment in the health and productivity of the next generation.

Making that case requires figures that a ministry of finance accepts, produced by someone it trusts. That is the purpose of each placement. The Network exists so that, when budgets are decided, children are part of the calculation and not what is left after it.

Contact us at hef@unicef.org

Notes and sources

The programme

- **UNICEF Health Economics and Financing Section.** Global survey of health economics and financing practice, November 2025. One hundred and twenty-one respondents across 55 country, regional and headquarters offices, in English, French, Spanish and Portuguese. Cited at letter F.
- UNICEF Health Economics and Financing 101 Guide, 2026: available on the Health Economics and Financing SharePoint site

Evidence cited

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- **Nastase A, Rajan A, French B, Bhattacharya D.** Technical assistance: a practical account of the challenges in design and implementation. Gates Open Research, 2021; 4: 177. Cited at letter Y.

Placement programmes consulted in designing the Network (letter K)

- **ODI Global Fellowship Scheme.** Established in 1963, when the first three fellows took up posts. More than 1,300 fellows have since been placed in over 50 public sector institutions across Africa, Asia, the Caribbean, the Pacific and the Western Balkans. Two-year contracts; fellows are employed and paid by the host institution and managed by local civil servants, in ministries of finance, planning, health and education, central banks, statistics offices and regulatory bodies. Overseas Development Institute, London. https://odi.org/en/fellowship-scheme/
- **World Bank Early Years Fellowship.** Launched in 2016 by the Early Learning Partnership of the World Bank Group to build in-country capacity in early childhood development across health, nutrition, education and social protection, and to reduce reliance on technical assistance from abroad. Three cohorts have graduated: 2017 to 2019, 20 fellows across 22 countries; 2020 to 2021, 25 fellows across 36 countries; 2022 to 2024, 14 fellows across 17 countries. Fellows spend a fifth of their time in a structured professional development programme.https://www.worldbank.org/en/topic/education/brief/apply-now-early-years-fellowship
- **Early Learning Partnership.** Early Years Fellowship Capstone Publication, Cohort 2. World Bank Group, Washington DC, 2023.

Web addresses were last checked in August 2026.

UNICEF'S HEALTH ECONOMISTS NETWORK

For sustainable health investments in children

About this publication

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