

Fit for the future: from siloed to integrated public health systems

Francesca Colombo, Michele Cecchini, Kerri Elgar, Alexa Blair Segal, Eric Sutherland



Despite compelling evidence on the value of prevention, public health remains chronically underfunded and structurally deprioritised. Spending on prevention has remained stable at around 3% of total health expenditure across Organisation for Economic Co-operation and Development countries for the past two decades, and despite a temporary doubling of spending during the COVID-19 pandemic, this trend has already reversed. The central challenge for the next decade lies not in the absence of evidence, but rather the absence of political will and systems capable of translating evidence into action. Three interconnected priorities stand out: (1) embedding public health in cross-sectoral governance frameworks so that prevention is assessed on equal terms with curative care; (2) strengthening data to support public health investment and budgeting, especially in a highly volatile fiscal environment for many countries; and (3) accelerating digital transformation to increase analytical ability, targeted public health intervention, and public trust. Progress in all three areas requires strong political leadership and rethinking current systems to ensure that they are fit for the future.

Introduction

Public health is facing a time of compounding pressures. Geopolitical tensions, financial instability, and increasing systemic risks are converging with demographic shifts that strain health systems. Non-communicable diseases (NCDs) account for around half of all premature deaths in Organisation for Economic Co-operation and Development (OECD) and Group of 20 (G20) countries.¹ At the same time, the resurgence of infectious diseases partly driven by environmental factors—as seen in the COVID-19 pandemic and the current Ebola emergency—reinforces the necessity of a One Health approach.² Rapidly intensifying threats (eg, antimicrobial resistance) add further strain to already pressured health systems. These overlapping health challenges are further compounded by poor international coordination in a fragmented global health architecture. Benefits often accrue to a narrow set of actors, with corresponding high public costs and adverse impacts on population health.

In this context, health policies need to shift their focus from health-care services that react to illness, to preventing risks and protecting populations, with spending priorities aligned accordingly. Yet public health policy remains a neglected priority. Across OECD countries, spending on prevention has remained broadly stable at around 3% of total health expenditure for the past two decades, with the exception of the COVID-19 pandemic, when vaccine procurement and laboratory capacity temporarily doubled that share to 6%.³

Several factors explain the persistent underinvestment in public health, starting with siloed policy making. Many preventive measures (eg, school-based interventions, regulation, and policies shaping the social determinants of health) require effective cross-sectoral responsibilities that span the health, education, transport, labour, and environmental sectors, and local governments. However, prevention policies are often assessed against more

stringent criteria than treatment, and formal mechanisms to systematically evaluate cross-sectoral effects are weak. This misalignment carries a substantial economic cost, especially in the context of ageing populations and insufficient labour productivity growth. For example, NCDs, which are largely driven by preventable risk factors, lower gross domestic product growth by about 3·8% on average across OECD countries.¹ Many information and environment policies can generate returns of €2–6 for every €1 invested when gains in workforce productivity are considered.¹ Despite this evidence, public health remains underfunded because decision-making frameworks, budgets, and accountability structures are not designed to capture these cross-sectoral benefits. Ministries beyond health have insufficient incentives to invest, even if there are gains for their own sectors.

Part of the reason that prevention remains underfunded has less to do with evidence than with who pays and who gains. The benefits of preventive interventions typically accrue over the long term and are shared across sectors, whereas the costs are immediate and borne by identifiable actors, such as finance ministries, local governments, or employers. This asymmetry creates resistance and weakens political demand irrespective of the robustness of the evidence. Those who stand to benefit from the investment (eg, future patients, taxpayers, and the wider population) are numerous and often not organised to advocate for such investments. Moreover, limited health literacy can reduce public awareness of the benefits of prevention. By contrast, those who bear the immediate costs are not necessarily the primary beneficiaries of the returns. This dynamic is particularly evident when stakeholders with vested interests influence policy processes, contributing to institutional and political barriers that hinder the adoption of preventive policies.

Moreover, effective public health requires investment at times when perceived urgency is low, and well before risks become visible or politically salient. Examples include immunisation campaigns, interventions to prevent

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Health Division, Directorate for
Employment, Labour and
Social Affairs, Organisation for
Economic Co-operation and
Development, Paris, France
(F Colombo MSc,
M Cecchini PhD, K Elgar PhD,
A B Segal PhD,
E Sutherland MMath)

Correspondence to:
Mrs Francesca Colombo, Health
Division, Directorate for
Employment, Labour and Social
Affairs, Organisation for
Economic Co-operation and
Development, Paris 75016,
France
francesca.colombo@oecd.org

obesity, disease surveillance systems, and national laboratory capacity. In an environment characterised by constrained public budgets, short planning cycles, and siloed financing between curative and preventive care and across sectors, these factors systematically disadvantage prevention investments. These constraints are not simply technical: short planning horizons reflect electoral incentives and political risk aversion. Because the returns on prevention often fall outside the electoral cycle, they offer little visible payoff to those deciding them. Addressing these structural issues requires better aligned incentives for policy making, alongside greater recognition and support for efforts to promote prevention, despite the challenges of attributing political credit to such measures.⁴ One way to narrow this gap is to prioritise interventions with effects that are measurable within a typical electoral cycle. For example, the OECD *Guidebook on Best Practices in Public Health* sets out how cost-effective interventions can be identified, evaluated, and scaled, and WHO has identified actions that stakeholders can prioritise over short time horizons.^{5,6}

The central challenge of the next decade is not the absence of evidence on the benefit of public health but the unavailability of systems that can support effective action and help drive political will. Moving from segmented approaches to more integrated systems, and towards stronger governance mechanisms underpinned by relevant data and evidence, are needed to ensure that public health is systematically considered in decisions on investment priorities. To achieve this, the public health community needs to address three interconnected challenges: (1) repositioning public health as a cross-sector investment priority supported by stronger governance; (2) strengthening data to better inform public health investment and budgeting; and (3) more effectively leveraging digital transformation.

Positioning public health as a cross-sector investment

Public health requires stronger governance to enable cross-sector coordination and investment. At the national level, although public health interventions generate substantial benefits beyond the health sector, these positive externalities are not consistently reflected in cross-government decision making. At the same time, producing evidence on cross-sectoral benefits and evaluating the co-benefits of public health policies are not sufficient on their own, but need to be systematically considered in policy and budget decisions. Cross-government policy formulation processes, medium-term expenditure frameworks, performance budgeting, and ring-fencing are key mechanisms to support cross-governmental decision making, improve fiscal predictability, align budget allocations with longer-term policy goals, and integrate information on the outcomes of public health spending into the budget process.⁷ Without these public governance changes, the availability

of evidence alone—the investment case—is unlikely to support resource allocation and decision making.

Similarly, at the global level (as seen during the COVID-19 pandemic), the misalignment of health, finance, and other sectors has hindered effective responses, amplifying negative health and economic consequences. This misalignment is fundamentally a governance challenge, requiring more integrated frameworks that align national, regional, and cross-border structures and institutionalise multisectoral foresight ahead of crises to mitigate cascading socioeconomic and health impacts.⁸ Progress has been made towards integrating global governance responses, such as the creations of the G20 Joint Finance–Health Taskforce under the Italian G20 Presidency in 2021, the Pandemic Fund in 2022, and the OECD Network of Senior Budget and Health Officials in 2011. However, much work remains to reform the global health architecture and reduce fragmentation to support more effective global responses on escalating public health challenges.⁹

Strengthening data reporting to support public health investments

Beyond improved governance frameworks, strengthening the availability and use of data is essential to support effective public health budgeting and decision making. Two-thirds of countries that report health expenditure data to the OECD acknowledge shortcomings; for example, few countries can confidently state how prevention budgets are allocated across prevention programmes, risk factors, population groups, or diseases. Expanding this type of granular reporting would strengthen accountability and support more informed prioritisation.

The main obstacle is not technical, but political. Because prevention budgets are not given the same priority as curative care, these budgets are not subject to the equivalent levels of scrutiny or accounting rigour as hospital or pharmaceutical spending. Addressing this imbalance requires stronger policy guidance, improved administrative data systems, and a change in approach to the assessment of public health investment. These improvements would also make post-pandemic declines in prevention spending more visible and actionable.

Important data gaps also remain in preparedness for future health crises. Although there is broad consensus on the certainty of further pandemics and despite broad estimates of investment gaps,^{10,11} there is still no agreed metric to track spending on pandemic prevention preparedness and response (PPPR). As a result, information on investments remains sparse and fragmented, with data sources often not comparable across countries. This is particularly relevant in many low-income and middle-income countries, where the rapid decline of OECD official development assistance (ODA) poses substantial new risks. Approximately 80% of the spending contributing to PPPR in low-income countries and 30% in lower-middle-income countries is externally

financed, mostly from ODA budgets.¹² Recent cuts to health ODA in 2024–25 have reduced funding flows to levels not seen since the mid-2000s.¹³ As increasing domestic resources and identifying alternative financing channels will take time, this reliance on aid has created a dangerous gap in global preparedness.

In this context, improving the measurement and comparability of PPPR spending is necessary to strengthen accountability and sustain investment. Consistent with a One Health approach that recognises the interconnected risks across human, animal, and environmental systems, this improvement requires more granular tracking of spending on public health threats, and extending measurement beyond the health sector to capture related cross-sectoral investments in animal health, agriculture, the environment, and security sectors.² A more comprehensive framework for tracking global health security spending would allow countries to identify key spending gaps, allocate resources more strategically, and strengthen resilience to future health shocks. To support this approach, starting from mid-2026, the OECD is collaborating with the European Commission, the G20 High Level Independent Panel, and other organisations to develop a methodology to routinely track PPPR financing.^{10,14}

Unlocking the potential of digitalisation

A final priority lies in the ability to translate growing volumes of health data and digital technologies into effective action and public trust. Digitalisation is rapidly expanding what health systems can do, from improving efficiency to accelerating research and enabling more predictive and targeted interventions. Advances in artificial intelligence (AI) have shown the potential to detect emerging threats earlier, with retrospective analyses indicating that COVID-19 indicators could have been identified as early as November, 2019, before any formal alerts.¹⁵ At the same time, the increasing availability of genomic, environmental, and population-level data is enabling the development of precision public health, which can deliver more targeted, timely, and effective interventions to specific populations.¹⁶ These developments offer opportunities to strengthen preparedness, improve outcomes, and increase the efficiency of public health systems.

Despite these advances, data remain underused to support public health decision making in practice. Across countries, persistent barriers (eg, fragmented data governance, insufficient interoperability, the need for trusted-data frameworks, and unequal access to data tools) continue to constrain effective data use. Before the pandemic, less than two-thirds of OECD countries reported the ability to link data across multiple care settings, and only a small number of countries could access key national datasets within a week.¹⁷ These limitations hindered timely responses during COVID-19, particularly for vulnerable populations.¹⁸ At the same

time, the rapid spread of misinformation and declining public trust during COVID-19 showed that data need to be accompanied by transparent communication and trusted governance frameworks to ensure data uptake and effectiveness.¹⁹

Although progress is being made, it remains uneven. Several countries are investing in digital infrastructure, strengthening their routine monitoring capacity, and expanding the use of data systems such as AI-powered disease detection, vaccination registries, and disease surveillance platforms.^{3,18} These initiatives are important, yet their impact to date remains constrained by small-scale and weak coordination across institutions, and modest progress in enabling cross-country data, with the exception of the developing European Health Data Space.

As a result, the expansion of data systems has not consistently translated into better health outcomes, improved decision making, or accountability. In the case of applications of AI in health, the growth in data and algorithms development has outpaced the development of governance frameworks, analytical capacity, and the workforce skills required to use AI safely and effectively. This disparity creates a growing imbalance, whereby data availability has expanded rapidly, but the ability to create timely, policy-relevant, and trusted information remains constrained. These factors limit the impact of digitalisation on public health outcomes and performance.⁷

The next phase of digital transformation in public health should therefore focus on four inter-related areas: (1) stronger data and AI stewardship models; (2) sustained investment in digital and analytical skills; (3) improving economic understanding of the costs versus the benefits of digital investments; and (4) the co-creation of digital public health policies with citizens.²⁰ These factors will be essential to ensure that improvements in data and measurement translate into more effective, trusted, and data-driven public health action.

Conclusion

The challenges discussed in this Viewpoint might appear distinct, but they emphasise the need for better integrated cross-sectoral and cross-government governance and more connected and well governed data systems and digital technologies. Achieving this aim will require political leadership and international collaboration to support and incentivise public health decision making and to agree on topline metrics for success over short-term political cycles, even when cumulative benefits materialise over the long term. Concrete mechanisms (eg, cross-sectoral budgeting) can help to realign incentives across ministries. PPPR spending trackers and routine measurement in public health can help to break the cycle of panic and neglect by creating a standing basis for holding investment in prevention and preparedness. However, the window of opportunity is narrow, as gains in measurement and tracking need to be secured before political attention moves on.

Contributors

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Declaration of interests

We declare no competing interests.

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