

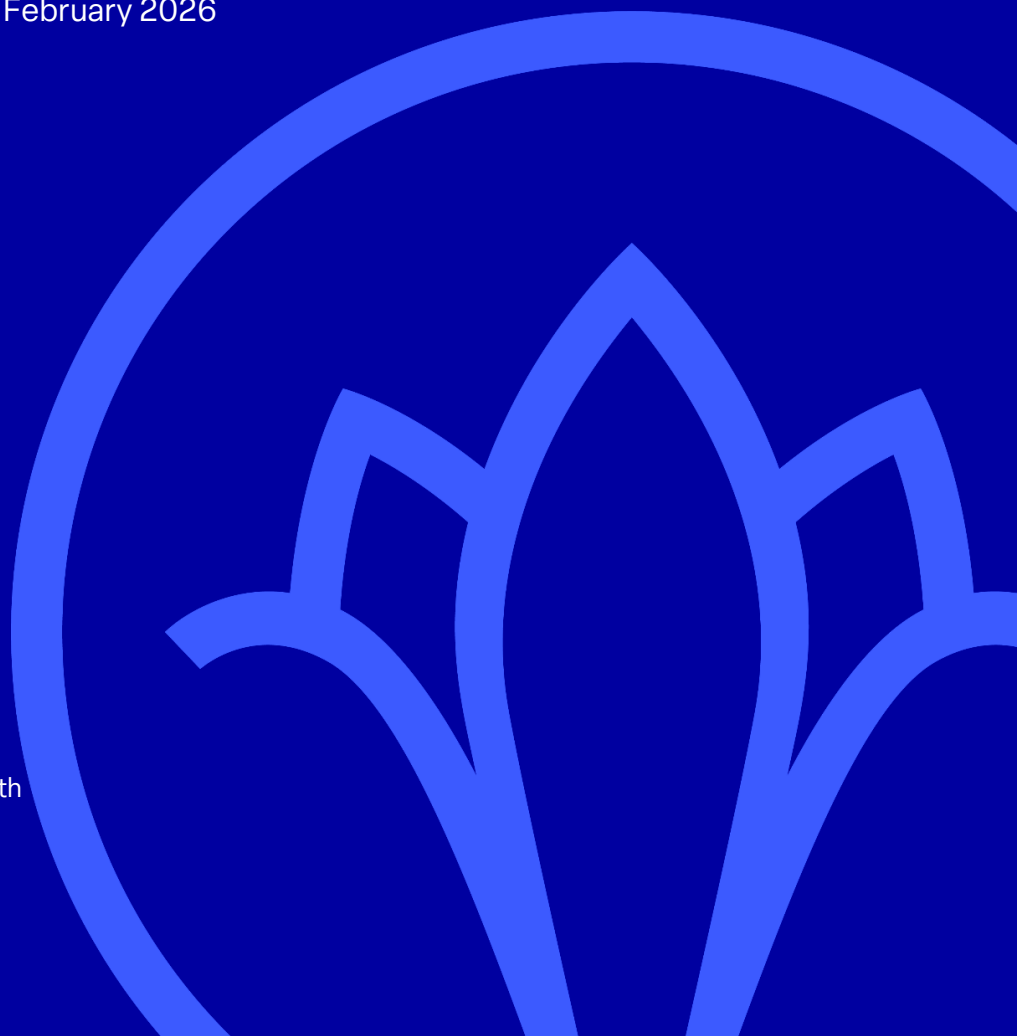


**Wilton  
Park**

# **Report: Leveraging digital public infrastructure for sustainable health system transformation**

Monday 2 – Wednesday 4 February 2026

**In association with**  
Foreign, Commonwealth, and  
Development Office, World Health  
Organisation, and Co-Develop



In association with



Foreign, Commonwealth  
& Development Office



**World Health  
Organization**



CO-DEVELOP

# **Report: Leveraging digital public infrastructure for sustainable health system transformation**

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## **Executive Summary**

Over three days in February 2026, senior government officials, multilateral institutions, development banks, civil society, academia, and the private sector gathered at Wilton Park. Their focus was a question that sits at the intersection of technology, governance, and public finance: how can countries sustainably leverage digital public infrastructure (DPI) to transform their health systems?

Representatives from across Asia, Africa, Latin America, the Caribbean, Europe, and North America gathered to take stock of where progress has been made, where systemic bottlenecks persist, and what concrete action is required to move the agenda forward. Discussions were frank, forward-looking, and grounded in country experience. Shaped by a shared recognition that the scale of current and planned investments in DPI creates both unprecedented opportunity and heightened responsibility: to avoid reinforcing silos, sectoral fragmentation, or investing in technical systems that outpace the governance and human capacity required to use them effectively.

The overarching message from the dialogue was clear – DPI is no longer primarily a technical challenge. It is a state capability challenge that requires political leadership, institutional reform, sound financing, and sustained investments in systems and people. While many countries now have foundational DPI components in place, health systems continue to underperform. Fragmentation is a defining feature in the current ecosystem: DPI for health is too often absent from investment decisions within Ministries of Finance and development organisations, governance structures are weak, and incentives are often misaligned. Yet the potential to leverage DPI for

sustainable health system transformation is vast and the foundations on which to build are, in many countries, increasingly in place.

## Highlights and emerging themes

- 1** DPI must be reframed not as infrastructure but as a way to enable services that deliver tangible value for patients, health workers, administrators, and political leaders.
- 2** The value proposition must be better articulated to show the tangible benefit for different stakeholders – from political leaders to health workers and service users.
- 3** Cross-sector collaboration is considered essential, but the realities of working across ministries and institutions remains complex – changing this will require realigning incentives and responsibilities, informed by practical guidance.
- 4** There is a need to identify and document pre-cursors and minimum dependencies related to financial, technical, and governance foundations so that countries can appropriately plan and effectively execute their (investments) in health sector transition to a DPI based approach.
- 5** Governance, not technology, is a primary constraint, and cross-cutting DPIs require institutional authority – and responsibility – above individual Ministries.
- 6** Financing models remain misaligned to the realities of scaling shared infrastructure, requiring a shift from project-based capital expenditure to longer-term, opex, service-oriented models.
- 7** Interoperability failures are more often institutional and political than technical and remain a critical dependency for successful digital transformation of the health sector.
- 8** State capacity – particularly in the absence of roles such as digital and enterprise architects within government and even within countries – represents a hidden but critical bottleneck.
- 9** The evidence base for DPIs for health needs expanding, including through case studies and exemplars which provide practical insights relevant to policy makers and practitioners alike.

The dialogue closed with concrete commitments to advance a shared agenda over the next three to six months, structured around five issue areas identified during the Day 3 action planning discussions. These include strengthening a community of practice, developing a value narrative for DPI in health, conducting a capacity gap assessment (which would inform training and coaching programmes), and further developing country case studies to anchor the evidence base.

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## 1. Status and trends for DPI for health: momentum lacking coherence

Participants pointed to significant momentum in the adoption of foundational DPI across low- and middle-income countries, with digital identity systems, payment rails, and data exchange platforms increasingly in place. The health sector has both benefitted from and contributed to this progress. Yet it was equally clear the potential of DPI for health remains far from fully realised. Notably, the health sector has accumulated considerable experience related to pursuing the goals of investment into common digital infrastructure, which will need to inform strategies for DPIs for Health. Implementation has too often followed narrow programme priorities driven by individual donors rather than national health system goals. This has resulted in fragmented digital landscapes in which patient identity systems, longitudinal records, and metadata registries have been designed and built in isolation.

Several trends emerged as particularly significant. For foundational DPIs, the growing involvement of development banks was noted as an important shift, creating both significant opportunity and risk. Opportunity comes from the potentially transformative scale of investment, yet without the right governance and technical conditions in place, this risks locking in the very fragmentation the field is trying to overcome. Participants also noted the persistence of vendor-driven solutions that create “walled gardens” – i.e. proprietary systems that undermine long-term interoperability and transfer costs to governments. The economics of infrastructure investment, as one participant put it, “basically sucks”, and without a dominant use case and a credible value narrative, political and financial buy-in remains elusive.

There was broad agreement that a fundamental shift is needed, one that sees DPI not as a collection of technology projects but as an enabler of public services provided by governments, delivering the standards-based capabilities needed to de-risk private sector solution development, and enable citizens to use those solutions effectively. This reframing has practical implications for how DPI is designed, procured, financed, and governed. It also changes the nature of the value proposition: rather than leading with technical specifications, advocates for DPI in health must articulate what it means for end users and beneficiaries, such as reduced waiting times, on-time payments and detection of fraud in supply chains. In this framing, a central role of government is to define and steward the specifications, standards, and architectural guardrails needed to ensure that investments contribute to a coherent DPI-based architecture that delivers value across all constituencies for health sector goals. There was an

acknowledged role for health sector-specific DPIs (health records, metadata registries, etc) and cross-sector DPIs (ID, payments systems, etc) each necessary for sustainable digital transformation of the health sector.

“Sustainability by design” was a recurring theme throughout the dialogue, positioned as a central principle for designing DPI for health. Five dimensions were outlined:

- 1 Value proposition** – the stories that articulate the real-life benefits, for governments, donors, and citizens (e.g. framed around ‘DPI as a service’)
- 2 Technical architecture and standards** – the pathways and foresight needed to move beyond silos and enable modular, interoperable capabilities that support multiple health sector goals and unlock the full potential of DPI for health.
- 3 Organisational structures** – the ways of working that overcome fragmentation, provide dedicated institutional homes, and realise the benefits of working across sectors.
- 4 Financial resilience** - the financing approaches and investment strategies needed to ensure DPI for health can be maintained, governed, and evolved over the long term with local resources.
- 5 Legislation** – the foundation that establishes trust and accountability and provide a basis for long term sustainability.

## Country perspectives

Several countries shared their experience directly, offering grounded insights into what works, what does not, and the conditions needed to make a difference.

- **Sri Lanka** demonstrated the value of investing in internal capacity building alongside digital infrastructure. The Postgraduate Institute of Medicine, under the leadership of the Ministry of Health, has created master's and doctoral programmes for medical professionals to build digital health technical literacy within this cadre. An “experience centre” was developed to help the public understand what they could expect from DPI-enabled services in practice in the future. Despite these advances, Sri Lanka has found it difficult to scale existing open-source solutions across its population of 22 million without additional external support.

- **Bhutan** established a central GovTech Agency as part of a whole-of-government digital reform, consolidating ICT resources across ministries. This has reduced duplication and enabled the development of a single, interoperable national data exchange backbone. While consolidation has strengthened national infrastructure, it has also created institutional challenges at the sector level, particularly due to the absence of a dedicated governance and technical anchor for digital health within the Ministry of Health. The experience has demonstrated that high-level political commitment alone is insufficient; effective digital public infrastructure requires sector-level institutions with day-to-day operational authority working alongside political leadership. Sustainable DPI depends not only on platforms, but on robust governance structures and skilled technical teams.
- **Zambia** presented a model with a governance body anchored in the Office of the President and created through an Act of Parliament. The independent entity has authority above individual sector ministries, a digital health working group (which is part of the Ministry of Health, and includes representation of Smart Zambia, the eGovernment division which sits under the Office of the President) spans multiple sectors, and has the technical capacity to advise political leadership on sound decision-making. Critically, no digital decisions can be taken without the involvement of this entity. The country is developing guidance on upskilling teams in enterprise architecture and is engaging universities as part of this effort.
- **From Latin America and the Caribbean** the [Pan American Highway for Digital Health](#) (PH4H) – a partnership between PAHO, the IDB, and countries of the region – was presented as a regional model for aligning and accelerating investments. The initiative, [approved by all countries of the Americas in the PAHO 61<sup>st</sup> Directing Council](#), frames digital health in terms of “traffic rules” (governance), “cars and drivers” (users and use cases), and “road-paving” (technical standards and digital infrastructure). PH4H also holds ['Connectathon' events](#), bringing together over 17 countries (with incentives such as innovation awards) to exchange data and drive collaboration between technical teams across borders. Through this work, the Americas has become the [first region in the world](#) to issue Digital [Yellow Fever Vaccine Certificates](#) using the [WHO Global Digital Health Certification Network](#). The IDB expressed openness to expanding participation in their connect-a-thons to other countries outside of the LAC region.

Across these country and regional perspectives, common themes emerged: the importance of institutions that outlast political cycles, the value of peer-to-peer learning and regional collaboration, the need for dedicated technical capacity rather than reliance on external consultants, and the central role of clear mandates backed by legislation.

## 2. Governance and institutional capacity

Governance emerged as the most consistently cited constraint on sustainable DPI for health, and breakout groups on this theme generated concrete analysis and recommendations.

Participants were candid about why silos persist: incentives in most systems reward vertical programme solutions rather than shared infrastructure. Career trajectories, procurement systems, and funding structures all create conditions in which departments are better rewarded for protecting their own systems than collaborating across boundaries. Coordination is, above all, a political economy problem, not a technical one.

While health sector-specific DPIs must be governed by the health sector, cross-sectoral DPIs require governance at a level above individual ministries. In practice, this often means anchoring authority in the President's or Prime Minister's office; not because health or finance ministers lack interest, but because only that level of political seniority can enforce coordination across sectors. While high-level political leadership is essential, alone it is not sufficient. It must be backed by empowered technical institutions such as secretariats, e-government/technology ministries, digital health agencies, or equivalent bodies, that each have clear mandates, adequate resources, and day-to-day operational authority. Agencies managing cross-sectoral DPI should embrace a service delivery mindset, engaging sectoral ministries (including health) early in planning and design to understand sector needs and use cases.

Groups explored the governance failures that most consistently undermine sustainability: the absence of clear accountability and decision rights; the lack of coordination mechanisms between health, finance, and technology ministries; and the failure to design for institutional and financial sustainability from the outset of a programme.

The suggestion for the development of a clear RACI (Responsible, Accountable, Consulted, Informed)-type framework to govern cross-sectoral DPI programmes emerged from the discussion. Establishing which parts of government, and non-

government are responsible for governing health sector content, who has ultimate accountability for the technology implementation, and ensuring the DPIs address health sectoral capability requirements, who needs to pay, and who needs to be kept informed (across health, finance, and digital government functions) was identified as one of the more practical and immediately actionable governance frameworks that needs to be developed for governments and their partners.

Participants emphasised the critical value of simplifying the language used to communicate about DPI to political decision-makers. One suggestion was to focus around three core things: reduce the burden of data collection on health workers, improve the quality of provider and patient interactions, and improve health outcomes. The need to provide evidence of cost-savings and efficiencies was also mentioned by participants. Politicians respond to narratives grounded in the concerns of their constituents and the realities of their political cycles, and DPI advocates must meet them there.

### **3. Technical Architecture and Country Capabilities**

Discussions on technical architecture moved beyond abstract definitions, towards the practical: what does a country need in place, technically and in terms of human capability, to build and sustain DPI for health?

Participants identified a fundamental gap between health architecture (which is concerned with real-time data sharing, care pathways, and clinical workflows) and technical architecture (which is concerned with platforms, standards, and interoperability layers). The roles that bridge these two domains - often described as health informatics architects or enterprise architects - frequently do not exist in government. Filling this gap was identified as one of the more urgent and actionable priorities, as well as identifying ways of retaining these skills within the government as there can be strong pull from the private sector within and outside the country.

On interoperability, one participant noted that technical interoperability is easier to achieve than human interoperability. Standards and semantics matter, but so do the business rules about how data is stored, accessed, and governed. These require negotiation across institutional boundaries, not just technical alignment. Participants argued strongly for open standards, modular architectures, and the deliberate development of local vendor ecosystems so that governments are not dependent on any single provider and can ensure that they can maintain and evolve DPI systems with local expertise.

Vendor lock-in was identified as a significant and persistent risk: proprietary systems may offer short-term convenience but create long-term dependencies that are difficult and costly to unwind. One participant stressed the need to avoid equating sovereignty with ownership; it is rather about choice – including the right to move to new systems or vendors over time. The importance of negotiating the right to move upfront, the cost of doing so – and who bears these – and the responsibility of different parties in facilitating a switch, was noted as being critical. Governments that define the architecture, technical specifications, interoperability standards, and leverage their mandate to coordinate and ensure procurement mechanisms are aligned, and that each subsequent investment into DPIs and functional applications are conformant to these specifications, will facilitate consistency across the digital health ecosystem.

The experience of the Asia eHealth Information Network (AeHIN) was highlighted as an instructive model for regional capacity building. AeHIN's training programme covers governance, architecture, project management and standards (GAPS), and has evolved to ensure that participants are not only trained but empowered to act when they return to their countries. The programme has been delivered across multiple countries and is increasingly asking participants to commit to specific, named actions upon return. A convergence methodology workshop approach is being used to reveal country-specific gaps and capability needs.

The World Bank has developed the [Digital Health Blueprint Toolkit](#), providing a comprehensive set of customisable resources designed to move from digital health strategy to implementation by focusing on the development of buildable blueprints contextualised to country health priorities.

Participants identified four interrelated priorities:

- 1 Clarify** the distinction between health architecture and technical architecture and create the roles to bridge them.
- 2 Develop** a principles-based framework to guide implementation decisions and link them to technical requirements.
- 3 Operationalise** WHO guidelines on reference architecture with the training and coaching necessary to do so effectively.
- 4 Build** 'soft' capabilities - including communications, change management, and advocacy- alongside technical skills.

Participants agreed that countries need a 'national digital architect'. This could be a role for an individual or a small team, accountable for overseeing the design of the

technical building blocks and the reference architecture of health DPI. This is not an IT manager, a vendor, or a donor-funded consultant – it is essentially an accountable designer of 'systems of systems,' embedded in government and empowered to make and enforce decisions.

## 4. Financing for Digital Health

The dialogue surfaced important distinctions and significant frustrations around financing and identified some of the most important practical steps available to the field.

Participants distinguished between two related but distinct financing challenges: financing for DPI in health (which encompasses architecture, human capital, and operational costs over time) and DPI for health financing (which involves using digital infrastructure to improve revenue collection, risk pooling, resource allocation, and accountability within health systems). Both are essential but often confused, and the field would benefit from greater clarity and a shared vocabulary around each.

On the first, a central theme was the need to move from capital expenditure-heavy, project-based funding to longer-term, operational expenditure-oriented service models. The current incentive structure, in which both vendors and governments often prefer vertical programmes because they are easier to procure and manage, actively works against the shared infrastructure model that DPI requires. Achieving the shift to sustainable financing requires building cost-recovery mechanisms into systems from the outset, integrating DPI budgets into national fiscal frameworks rather than treating them as donor-funded line items, and engaging Ministries of Finance as strategic partners rather than passive funders.

On the second, groups identified priority health financing use cases that DPI can advance: measuring total health expenditure, pooling resources for shared services such as insurance, measuring out-of-pocket expenses, managing supply chains and detecting leakage, fighting fraud, and enabling more equitable allocation of resources and timely payments to health workers. Each of these use cases requires reliable, interoperable data, and each offers a compelling narrative for Ministers of Finance, who respond to language around efficiency, accountability, and fiscal control.

The financing community's limited understanding of DPI was identified as a significant structural barrier. Participants called for investment cases tailored to different audiences. This includes not only health ministries and donors, but also development banks, Ministries of Finance, and, where relevant, the private sector. The question of

how to monetise DPI and create revenue streams that reduce long-term dependence on external support was raised but acknowledged as requiring further work. This is linked to the need identified for agencies responsible for cross-sectoral DPI (such as ID) to articulate to sector ministries the “menu” of services, costs, and clear steps for utilising the DPI services within their sector and allowing for within-country cost recovery.

## **5. Recommendations and Actions for Next Steps**

### **The Way Forward: Priorities for Action**

Participants left the dialogue with a shared agenda and concrete commitments to be advanced over the next three to six months. These actions are being take forward by different participant groupings and will also expand to others not engaged in the Wilton Park dialogue.

### **Value Proposition and Narrative**

Develop DPI-for-health value narratives tailored to four distinct audiences: political leaders, finance ministries, health providers, and citizens. These narratives will lead with outcomes and services rather than infrastructure and will be grounded in an expanding evidence base built through a collaborative research agenda and the documentation of quick wins from existing work. A co-authored article will be produced to advance the public case.

### **Governance and Accountability**

Produce practical guidance on establishing cross-sector DPI governance bodies, covering roles, mandates, and accountability frameworks, alongside a governance readiness assessment that countries can use to evaluate their capacity to succeed with DPI for specific health sector goals. This “pre-cursor” assessment will help countries and partners identify what governance conditions must be in place before committing to shared service investments and will describe governance archetypes and decision criteria rather than prescribing a single institutional model. Partners will actively encourage heads of state to make public commitments to foundational DPI bodies – a signal that this agenda sits above any single ministry or programme and requires sustained political ownership.

### **Financing Models**

Work to shift financing from project-based capital expenditure to service-oriented, multi-year models oriented around the full lifecycle of shared digital capabilities. This includes piloting cross-ministry cost-recovery and shared-benefit approaches

explicitly linked to domestic financing mechanisms such as health accounts and insurance, developing investment cases for development banks that connect DPI capabilities to measurable unit costs and operating models, and engaging Ministries of Finance as strategic partners in the design and resourcing of shared infrastructure. A cross-sector convening will be held to help advance this agenda.

### **Capacity and Skills**

Conduct a capacity gap assessment across low- and middle-income countries, with a survey launching at the end of February 2026<sup>1</sup>. Findings will directly inform the development of curricula and coaching programmes, with a particular focus on digital and enterprise architect roles that are currently absent from most government structures. All training programmes will include re-entry plans to ensure learning translates into action.

### **Exemplars and Use Cases**

Finalise four to five country case studies – drawing on experience from Ethiopia, Zambia, Sri Lanka, and the Philippines – to demonstrate concrete impact and provide an accessible evidence base for advocates and decision-makers. A shared inventory of available materials will be developed, and key findings synthesised into formats suitable for a range of audiences.

### **Community of Practice**

Continue to foster a DPI-for-health community of practice. Over time this can become a living home for shared tools, lessons, and guidance, and will draw on an existing knowledge base to connect practitioners across countries and institutions. This is expected to grow organically over time.

### **Communications and Advocacy**

Develop an audience map identifying champions, key entities, and tailored messages for each audience. This would be paired with a repository of key messages linking DPI to health outcomes, service quality, and fiscal efficiency. Together these will equip partners to engage consistently and effectively across major global forums throughout 2026. A white paper, co-authored by members of the group, will also be produced to advance the broader advocacy agenda.

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<sup>1</sup> Planning is underway for this.

## 5. Conclusion

The Wilton Park dialogue on DPI for health confirmed that the field is approaching a potential tipping point. The foundational elements – the technologies, the frameworks, the country examples, and the institutional networks – are increasingly in place. What has been slower to develop is the political economy of change: the leadership, governance, financing mechanisms, and institutional capacities needed to move DPI from pilots and projects to national systems that countries can own, operate, and sustain beyond external financing and technical support.

The dialogue also sharpened the nature of the risk. At the scale of investment now being contemplated, the risk is no longer limited to unsuccessful pilots. Rather, it is linked to long-lived architectural lock-in, fragmented governance arrangements, and operating models that embed dependency and recurring cost structures without building durable domestic ownership. This framing raised the stakes of the conversation and gave urgency to the three interconnected pillars that structured the dialogue: governance and institutional capacity, technical architecture and country capability, and financing and economic logic. Participants converged on the view that these pillars are mutually dependent – governance determines who has authority to enforce standards and coordinate across sectors, architecture defines what shared services exist and how they interoperate, and financing determines whether those services can be operated and evolved over time.

Participants were honest about the barriers, including some that the field has been reluctant to name directly: the perverse incentives that reward silos, the limitations of donor-driven programme cycles, the persistent gap in enterprise architecture and translation capacity within government, and the failure to connect DPI advocates with the political and financial decision-makers who ultimately control investment. Critically, many of the levers that matter most for DPI in health – identity, payments, public financial management, cybersecurity, and national interoperability governance – sit outside the Ministry of Health. Sustainable DPI for health requires cross-sector decision rights and enforcement mechanisms that most governance arrangements do not yet provide.

Participants emphasised that countries will only adopt and sustain DPI for health if they are convinced it is in their interest and if the conditions for success are genuinely in place. The role of the international community is not to push DPI onto governments, but to help create the enabling conditions: shared governance frameworks and readiness assessments, credible value narratives grounded in evidence, peer learning

platforms, training and coaching programmes, and financing instruments aligned with how infrastructure scales across different country contexts and digital transformation maturity.

Lesley-Anne Long and Henry Mark

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[enquiries@wiltonpark.org.uk](mailto:enquiries@wiltonpark.org.uk)

Switchboard: +44 (0)1903 815020

Wilton Park, Wiston House, Steyning,  
West Sussex, BN44 3DZ, United Kingdom

**[wiltonpark.org.uk](http://wiltonpark.org.uk)**

