Insights on global health reform discussions, trends and perspectives

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This is the second in a series of *Insights papers* summarising our understanding and analysis of global health reform discussions, trends and perspectives. It follows our first paper, published in early November 2025. We will continue to share regular updates and analyses around key issues and decisions in what will be a critical 12 months for shaping the future of global health.

Our reflections and assessments

This section summarises our reflections and assessment of developments in global health since the November Insights paper, offering a focused, critical analysis of the latest discourse. Descriptions of specific processes and events we have been following are provided in the main text of the paper.

In conversations around the future of global health, attention continues to be directed at diagnosing the problems in the existing ecosystem, though most of these have been long-known, well-researched, and extensively described. What is new today is the unprecedented amount of interest in systemic reform. Yet the enthusiasm to discuss and debate has thus far not translated into a clear vision for how best to harness this momentum. Continued bold thinking is essential, but it must be accompanied by bold action.

There is still considerable tension between long-term vision and the necessity for immediate responses, including within the global health institutions that continue to operate in a more financially constrained, uncertain environment. The imperative to streamline the current system is clear, but doing so without transformational shifts in governance, financing, power, and accountability will only deliver superficial change.

This point is highlighted in recent writing by Muhammad Ali Pate, Donald Kaberuka and Peter Piot, who identify opportunities for consolidation across the global health institutional landscape. Importantly, they frame consolidation as a means rather than the goals of global health reform. This is a crucial distinction, as the need for simplification predates the ongoing financing crisis, and a more cost-efficient system does not necessarily equate to a more just and equitable one.

The primacy of health sovereignty is a common principle across reform initiatives and debates; what differs is the way sovereignty is conceptualized and the extent to which it is deemed feasible. This is exemplified in the language employed by different actors, and whether they promote a system grounded in solidarity or subsidiarity, position themselves as donors or partners, and frame their role as shaping, leading or supporting the global health reform agenda.

It is widely acknowledged that systemic change hinges on transforming the global health financing architecture. Reforms are expected to support a transition from aid-based to domestic health financing, while identifying new forms of international finance to fund essential global functions. Shifts across the development landscape and changes in the principles of development cooperation may have significant implications for health and should thus be closely followed in the coming months.

The European Commission continues to articulate a sense of responsibility for global health, while at the same time emphasizing that meaningful reform must be driven by

L/MICs. This has contributed to a somewhat hesitant stance, with Europe mainly reiterating the principles of the Lusaka Agenda and seemingly awaiting a more transformative yet legitimate South-led proposal to endorse.

By contrast, the US has largely abandoned the narrative of collective global responsibility, with the singing of bilateral compacts being a first step in implementing the America First Global Health Strategy. The US withdrawal from the WHO did not signal a complete retreat from global health, but rather a radically different, overtly transactional approach to how it exerts its influence in this space. The overall implications of this shift will take time to fully understand.

Countries entering the multi-year bilateral agreements with the US likely see this as a pragmatic solution to address immediate domestic needs. A major critique is that while the agreements provide critical funding, they leave countries with little to no space to set their own priorities. Although they may provide a window of time to stabilize and increase domestic spending, the potential consequences of countries failing to meet ambitious financing targets are unclear. As of January 2026, most of the agreements remain unpublished and there are more questions than answers, including on the full obligations of signee countries and how these will be operationalized.

The precariousness of the multilateral system's future role extends well beyond health but presents a key tension for global health reforms. With the pursuit of health sovereignty being at the forefront of most discussions, the responsibilities of the 'global' system are yet to be agreed upon. Ensuring that the global system complements rather than impedes national and regional structures will prove vital for maintaining its relevance. As the multilateral system continues to face strain, there is a question if countries will increasingly turn to bilateral arrangements, possibly leading to further dissonance between global and more localised levels of health governance, and inhibiting continental collaboration.

Momentum for systemic global health reforms grew in late 2025. Amid ongoing turbulence, discussions have been converging on the view that 2026 must focus on developing broad consensus and coalitions of the willing on reform priorities, and most importantly, a roadmap for how to deliver such change. This would enable reform-related decisions to be implemented in the next 2 years, capitalizing on the political and institutional commitment for meaningful reform before it wanes.

Overall, one of the key questions for this year is whether the ideas and outputs coming out of the various reform initiatives will translate into political processes and actions.

A summary of ongoing reform discussions, trends and perspectives

Building on the November 2025 paper, this section provides an overview of processes and voices shaping the current reform discourse and a synthesis of the key discussions.

November and December were marked by several high-level events during which the future of global health was discussed. These included the G20 Leadership Summit, the 7th African Union – European Union Summit, and the Global Fund's Eight Replenishment Summit. Additionally, the Wellcome Trust regional dialogues and the European Commission reflection process on global health reform were finalized. Several countries also signed bilateral health compacts with the United States; these form a central tenet of the America First Global Health Strategy, which we discussed in the November paper.

Academic, think-tanks and other contributions

In a piece for Think Global Health, published in early January, **Muhammad Ali Pate, Donald Kaberuka and Peter Piot** set out a suite of reform options for global health institutions; reiterated that global health reform efforts must go beyond pursuing efficiencies, and outlined 10 considerations for reform initiatives, including the need to frame domestic investment in health as a national development priority; use 2026 to define a clear strategy for the way forward; and leverage coalitions of the willing to drive change. The authors published a more elaborate report on the Accra Reset webpage.

As a part of its ongoing Mind the Gap series, the **Centre for European Policy Studies** published a report titled A paradigm shift in global health and multilateral funding, providing a detailed overview of the changing ODA landscape and its implications on population health and multilateral institutions.

In **Foreign Affairs magazine** (December), **Finnish president Alexander Stubb** argued that a more equitable power distribution within international institutions is a pre-requisite for their survival in the emerging new world order. Acknowledging that global challenges of today cannot be resolved through coalitions restricted to like-minded countries, Stubb endorsed partnerships grounded in 'values-based realism'.

The convenors of **Wellcome Trust regional dialogues** on global health reform published their respective outcome reports, which will feed into a global synthesis paper ahead of a cross-regional conversation in 2026. All reports highlighted that the current global health architecture was no longer fit for purpose nor serving regional priorities. Across the reports, there was a strong emphasis on co-creation of the new architecture and calls for operationalizing and strengthening existing regional structures instead of establishing new ones. The need to make use of available mechanisms in global health was especially salient in the African report, which argued that: '*the challenge is not a lack of vision but rather the chronic failure to implement known commitments*'.

The World Health Summit and the Konrad-Adenauer-Stiftung organized a high-level strategic forum on 'Europe's Role in Reshaping the Global Health Architecture', gathering decision-makers from European institutions, the German Bundestag, United Nations, civil society, industry, and academia. One of the key takeaways was that Europe has a responsibility as well as strategic interest in global health system strengthening. Europe's convening role was described as a core strength, and Europe was perceived as having *'a decisive role in shaping the future of global health'*. However, it also stated that the next phase of reform must be led by low- and middle-income countries and regional institutions, with Europe and North America playing enabling roles.

African Center for Economic Transformation and the Center for Global Development announced the Future of Development Cooperation Coalition, conceptualized during the Financing for Development Conference in Sevilla with a goal to design a renewed development cooperation model. Countries supporting the Coalition are Belgium, Canada, France, Germany, Ghana, Ireland, Malawi, Mexico, Nepal, Republic of Korea, Senegal, Singapore, Somalia, South Africa, Spain, the United Kingdom, and Zambia.

Regional and state-led convenings and processes

Ahead of the **G20 Leaders' Summit**, **the Africa Expert Panel** published a report *on Growth, Debt and Development*, setting out a plan for new African partnerships, focused on maximising the potential of African human and natural resources through economic growth and productive investments. Sovereign debt crisis, insufficiently addressed by the 2025 G20, was seen as the key impediment to realising this vision.

Hosted by the South African G20 presidency, the Summit resulted in the Leaders' Declaration which has been perceived as an important, if only symbolic signal of openness towards continued diplomatic engagement. When it comes to health, countries agreed on the importance of several issues, from strengthening finance and coordination of pandemic prevention, preparedness, and response, including sustained collaboration with the Pandemic Fund; encouraging domestic public financing as the primary source for health finance; and recognising the role of the World Health Organization, as outlined in its constitution. Yet there were few clear timebound commitments to act on. The Declaration also made explicit reference note of the Lusaka Agenda, with strong backing from Norway.

Following the Summit, the **South African presidency and the Guardians' Circle of the Accra Reset** issued a joint statement. The group comprises distinguished heads of state, governments and international organizations who serve as public champions and moral guardians of the Reset. The statement laid the foundation for integrating the Accra Reset Agenda into the Africa Engagement Framework of the G20. This partnership aligns with the ambitions for the Accra Reset outlined by President Mahama during the 80th UN

General assembly, where he presented it as a framework for transforming global governance for development, encompassing but not limited to health-related reforms.

In the lead up to the AU-EU summit, **the Africa-Europe Foundation** published its State of Africa-Europe 2025 report, endorsing a fundamentally different approach to cooperation between the two blocs. Moving away from aid to domestic resources was central to reimagining partnerships across all areas, including health. Some of the specific priorities highlighted in the health domain were investing in local manufacturing capacity and operationalising the African Medicines Agency. The report pointed to taxation; leveraging sovereign wealth, pension funds, green, diaspora and blue bonds; and addressing the persistent issue of illicit financial flows, as potential strategies to unlock capital within the African continent.

The meeting of Heads of State and Government of **the African Union and the European Union** in Luanda marked the 25th anniversary of the AU-EU partnership. The gathering culminated in a joint declaration, with several points of relevance to health. Leaders recognised debt service as a major obstacle to development, preventing countries from investing in health systems, education and infrastructure, and encouraged G20's efforts to strengthen the Common Framework for Debt Treatments. They stressed the urgency of global health reform, calling for country-led systems that prioritise health security and universal health coverage, as well as complementarity between regional and multilateral fora. The importance of tackling illicit financial flows and establishing well-functioning tax systems was also emphasised.

The Centre for Global Development produced a series of blogs presenting ideas on several policy areas discussed at the Summit.

The burden of sovereign debt was quantified in an analysis by **ONE**, with 33 countries being in, or at high risk of debt distress.

Africa CDC unveiled a new agenda for health security and sovereignty across the African continent, mirroring the pillars of the New Public Health Order, with the addition of digital transformation and reform of the global health architecture. The agenda also references organisation's interrelated work, including the Africa Health Financing in a New Era concept paper and the African Pooled Procurement Mechanism. Africa CDC chief Jean Kaseya published a corresponding comment in the Lancet.

In early December, **United States signed the first bilateral compact under the *America First Global Health Strategy***, entering into a five-year $2.5 billion agreement with Kenya. Other agreements, varying substantially in size, have been signed with 13 other African countries, with more likely to materialize in the months ahead. Concerns have been raised about data sharing obligations potentially posing constitutional and sovereignty risks, which lead to Kenya's High Court suspending the deal on 11 December. Moreover, the terms for sharing pathogen samples and data threaten to undermine the ongoing PABS negotiations in Geneva.

UNAIDS released a statement welcoming the partnership between Kenya and the United States, describing it as a milestone in the future of global health cooperation. However, this does not appear to be a widely shared sentiment, with many scrutinizing the publicly available information on the bilateral global health deals.

The Center for Global Development provided an overview of what is known so far about the bilateral compacts, all of which tie US funding to an increase in domestic health spending by the partner governments, and represent an overall reduction in US health spending for each country. In an article for Global Policy journal**, Nelson Aghogho Evaborhene** discussed the potential consequences of the emerging bilateral partnerships on continental unity and the credibility of African health sovereignty agenda, underscoring that external agreements should not undermine regional structures.

Updates from multilateral institutions

Among notable publications, in November **the World Bank Group** released the first report in its annual *Government Resources and Projections for Health* series, which monitors government spending on health in low- and lower-middle income countries. The report, titled *At a Crossroads: Prospects for Government Health Financing Amidst Declining Aid*, projects moderate increase in government health expenditures towards 2030, but warns that this will be offset by drops in aid. Authors underscored that the available resources for health are determined by macro-fiscal factors, particularly economic growth, tax base and collection, and debt structures. Although more effective gathering of public revenue is important, it must be coupled with the political decision to direct funds to the health sector and prioritise cost-effective health interventions. Some countries are estimated to have the capacity for increasing resource allocation for health within the existing fiscal space, alongside having room for improving budget execution in the health sector.

During its Replenishment Summit in Johannesburg, **the Global Fund** raised US$11.34 billion, including a US$4.6 billion pledge from the United States. However, this sum fell below the Fund's US$18 billion target for the next three years, sparking concerns among civil society actors. Additionally, the conditions of US' support and the institution's role in implementing the *America First Global Health Strategy* remain uncertain.

The World AIDS Day was widely commemorated on December 1st under the theme *Overcoming disruption, transforming the AIDS response,* including in a statement by the UN Secretary General. However, the US Department of State has for the first time advised against using governmental funds to mark the day.

Gavi held a board meeting at the start of December in Geneva. While there was an appetite to discuss Gavi's positioning within the broader global health reform agenda, this topic was not included as a dedicated agenda item. Constituencies requested that it be added to the agenda for the next board meeting.

In preparation for the Executive Board meeting in February, **WHO** published a report to accompany the provisional agenda item on *Reform of the global health architecture and the UN80 Initiative*. The report acknowledges the shortcomings in current global health governance, coordination and financing, outlines some of the ongoing reform initiatives, and proposes that WHO brings them together by hosting an overarching joint process in the first half of 2026. In doing this, WHO seeks to engage the 'full range of global health actors' and build on lessons learnt from ACT-A.

About us

The Partnership for International Politics and Diplomacy for Health is a collaboration between the Stockholm School of Economics and Karolinska Institutet. Our work consists of four complementary and mutually reinforcing work streams: an Executive Program for future health leaders, the Health Diplomacy Institutional Network, focused Research efforts, and Policy engagements.

Our policy work seeks to contribute to the international dialogue on what a reformed international ecosystem for global health could look like. We call this workstream ***Paradigm Shifts for Global Health - Supporting Diplomacy and Policy Pathways.*** This is not a standalone initiative or process, but a means through which we engage as both originators and conveyors of ideas that could potentially assist in paving the way for a reformed international ecosystem for health.

Read more here: https://globalhealthdiplomacy.se/policy-engagements