Rebalancing the Scales: A New Architecture for Global Health Justice

by Paola Abril Campos Rivera

A Perspective from the Latin America and Caribbean Region

Recent political and financial shifts present an unprecedented challenge to global health, but also a long-awaited opportunity for significant reform. Wellcome has asked five global health thought leaders from different regions to explore what a reimagined global health architecture could look like. These five proposals are intended as a starting point to kick start regional and global conversations. The proposals are not expected to be representative, or consensus based, but to provoke discussion and debate.

Executive Summary

This proposal advances a bold and necessary vision for a new global health architecture; one grounded in regional leadership, supported by a fairer global financial system, and guided by a clear moral purpose: health justice. Global health with justice demands more than technical cooperation or development assistance of health. It requires a deliberate effort to confront exclusion, correct historical imbalances, and embed principles and mechanisms of fairness in the design and governance of global health institutions to address current challenges, particularly economic and commercial determinants of health, and climate crisis.

The convergence of ethical, political, technical, and delivery failures points to the limits of the current global health architecture. The challenge is no longer one of marginal reform, but of redefining the purpose and the functions of the architecture. Rather than reinforcing donor-led, centralized models, the new architecture should function as a distributed network that empowers regional health governance and centres country leadership.

A reimagined WHO should retain its core global functions—stewardship, norm-setting, and emergency coordination—while devolving technical and policy-related tasks to regional institutions. WHO regional offices should be restructured into agile bodies focused on delivering regional public goods, coordinating South–South cooperation, and supporting country-led priority setting. WHO country offices should be significantly scaled back — except where system fragility requires their presence.

To move from aid to investment, the proposal calls for the adoption of the WHO Council on the Economics of Health for All principles and alignment with global financing reform agendas such as the Bridgetown Initiative. It proposes redirecting global funds into regionally anchored financing mechanisms that support long-term health system strengthening and the production of regional public goods.

For Latin America and the Caribbean, the proposal outlines four key steps: redesign PAHO into a strategic enabler of regional capacity; create CRESALC, a regional public health centre with a broader mandate than disease control; launch the LAC Health Justice Knowledge Atlas, a transparent data platform; and establish the LAC Health Justice Fund to enable pooled investment in shared health priorities. Together, these reforms aim to shift the balance of power and advance structural change toward a more just and effective global health system.

Introduction

Today's global health architecture is falling short in its responses to global challenges and requires major rethinking and restructuring. Although the global health architecture achieved important goals in the past (for example, lives saved in responses to HIV and tuberculosis), it failed to perform well during the COVID-19 pandemic. While vaccines were discarded in high-income countries, frontline health workers waited for their first doses in low-income nations. This stark contrast exposed the inability of current institutions and processes to perform effectively and equitably when confronted with a global health crisis. Rather than correcting power imbalances, the global health architecture reinforced the imbalances and responded in ways that reflected existing power disparities [1-4]. This situation needs to be fixed.

Over the past two decades, the global health architecture has expanded with more actors, more funding, and more initiatives. But expansion has not meant coherence. Fragmentation, donor dominance, and weak accountability have limited the system's ability to respond to fast-moving crises and structural health threats. Geopolitical tensions, rising nationalism, and shifting financial priorities have made the global landscape even more complex and underscore the urgent need for a redesign of the institutions, norms, financial flows, and processes that make up the global health architecture so it can better address the pressing health, political, and ecological realities of our time.

This paper advocates not merely for incremental reforms to the global health architecture, but for a paradigm shift, one that reorients the balance of power to ensure that all individuals and communities possess the real capacity to attain and sustain good health. This requires a fairer distribution of power, decision making and knowledge generation, so that all countries, especially those long marginalised in the Global South and bearing the greatest burden of health threats such as climate change, have an equal opportunity to shape and benefit from the functions of a new global health architecture.

A crisis of ethics, power, and effectiveness

Meaningful reform must begin with a clear diagnosis[5]. Identifying problems and their causes is essential to finding the right levers for sustainable reform. The current global health architecture is not merely in crisis due to funding gaps or coordination failures; it faces a deeper crisis around ethics and power.

1. **An ethical challenge:** There is a lack of sustained commitment to addressing the social and structural conditions that shape both overall health and who has the opportunity to be healthy, particularly for those who are most vulnerable[6,7]. Despite widespread rhetoric around equity, the global health architecture lacks a practical framework and institutions that prioritize the needs of the most disadvantaged.
2. **A political challenge:** Decision-making around priorities and resource allocation remains heavily concentrated among a small group of donor governments, philanthropic actors, and disease-specific public-private partnerships[6,8]. Low-and middle-income countries, along with civil society, may have a seat at the table but they exercise little real influence[2,9]. This concentration of agenda-setting, financial control and normative authority leads to a persistent misalignment between external funding flows and national priorities. It also undermines mutual learning, and reinforces dependency on external resources[2,9]. Additionally, many institutions operate without transparent governance or effective mechanisms for public oversight, making it difficult to assess how decisions are made or who benefits from them.
3. **A technical challenge:** Fragmented and donor-driven financing systems create inefficiencies—such as parallel procurement channels, overlapping technical assistance missions, and missed opportunities for economies of scale. These inefficiencies divert attention and resources from long-term system strengthening toward short-term, externally defined targets[10].
4. **A delivery challenge:** The absence of shared goals and binding cross-cutting performance metrics makes it difficult to assess collective progress or ensure accountability. Without a clear framework for measuring impact, collaboration and coordination remains weak. In addition, everything seems a priority, thus accelerating progress on anything becomes difficult to measure or sustain.

This convergence of ethical, political, technical, and delivery failures points to the limits of the current global health architecture. The challenge is no longer one of marginal reform, but of redefining the purpose and the functions of the architecture.

Reorient the architecture towards health justice

Infectious diseases played a key role in shaping the foundations of multilateralism, with yellow fever in the Americas prompting the creation of the Pan American Health Organization (PAHO) in 1902[11].Today, there is growing evidence and recognition that social, economic, and political factors play a major role in shaping health outcomes[12]. The products and practices from key commercial sectors, including tobacco, alcohol, ultra-processed foods, fossil fuels, and pharmaceuticals, contribute to increase preventable health burdens and environmental degradation[13,14]. At the same time, the emerging paradigms of One Health and Planetary Health are shaping the global health agenda for this generation[15]. Human health is inseparable from planet's health and the ecosystems that sustain life. Addressing climate change, biodiversity loss, and emerging diseases requires cross-sector collaboration and shared resources across human, animal, and environmental health systems.

Reorienting the global health architecture towards health justice is essential to address the structural conditions that shape the health of populations. A new era requires a new paradigm—one that shifts power, centres justice, and aligns institutions and financing with the goal of health justice. This calls for a clear and ambitious moral purpose to guide global health actors and norms. At a minimum, the architecture must be able to hold the line against widening health injustices. At its best, it should redistribute power and resources to enable all populations, especially those historically marginalised, to thrive.

To achieve this, the architecture must be restructured around three core functions: producing global health goods that advance health justice, enabling collective action focused on the most affected populations, and holding actors accountable to shared norms of fairness, transparency, and inclusion. These functions must be supported by institutions explicitly designed to correct power imbalances.

Global health with justice demands more than technical cooperation or development assistance of health; it requires a deliberate effort to confront exclusion, correct historical imbalances, and embed principles and mechanisms of fairness in the design and governance of global health institutions to address current challenges, particularly economic and commercial determinants of health, and climate crisis[1,2,16].

Shift the centre of gravity

Leveraging regional institutions and building regional capacity would allow countries to take on key functions that have long been concentrated in global actors—such as setting priorities, generating knowledge, providing technical assistance, and mobilising resources. This shift would place greater responsibility at the regional level but would ideally come with sustained investment in regional platforms and institutions. It would enable greater transparency and legitimacy by bringing decision-making closer to the populations affected and fostering stronger regional ownership. This transition is already underway in areas such as vaccine production, where initiatives like Gavi's regional manufacturing strategy aim to strengthen regional supply chains and reduce dependency on a few global producers. The lessons emerging from the formation of the African Union can help inform regional efforts elsewhere, and subregional platforms such as CARICOM should be recognised and meaningfully integrated into the new architecture.

In a multipolar world, a distributed global health architecture built around empowered regional nodes offers a more legitimate and resilient alternative to the current Global North donor-led model. The challenge ahead is to design institutional arrangements that not only shift power but also ensure accountability—both to the countries and communities within each region, and to global norms of equity, justice, and collective responsibility.

Refocus WHO

In this new model, WHO should be reformed to focus its efforts on three core functions to strengthen the global health architecture: stewardship, setting international norms and standards, and coordinating emergency preparedness and response. These functions require a global mandate and depend on the organization's convening power and neutrality. However, other functions, such as shaping the research agenda, doing research, articulating policy options, and providing technical support, should be devolved to regional actors. WHO should actively enable regional leadership in these areas by supporting the development of strong regional and national institutions. Knowledge generation should be anchored in regional and country-level institutions to ensure relevance, ownership, and responsiveness to local contexts.

Re-design WHO's regional and country offices

WHO regional offices should evolve into nimbler, results-oriented institutions focused on delivering regional public goods and tracking progress. Their core functions should include developing regional standards, supporting the production of regional public goods for health, and coordinating South–South technical cooperation—replacing the traditional model of North–South assistance. They should work through and alongside national institutions, leveraging local expertise and strengthening regional capacity rather than duplicating it.

Regional offices should also maintain a comprehensive overview of development assistance for health in their region and help countries engage global actors and multilateral organizations to align financing with nationally defined priorities. They can keep a transparent registry of country's defined needs to guide funding; by doing so, they can foster greater coherence. Additionally, they are well positioned to promote and monitor the Lusaka Agenda, especially around joint approaches for achieving equity in health outcomes; strategic and operational coherence; and regional manufacturing[17].

Given the growing capacity of national institutions and the increasing reliance on national experts to provide technical assistance, the role of WHO country offices should be significantly reduced. These offices should be maintained primarily in contexts of humanitarian crisis or severe system fragility, where they can provide targeted support without crowding out national leadership.

Reshape global health financing by moving from aid to investment

Advocate for Health as public investment

Health must be treated as a long-term public investment, not a short-term cost. Shaping a more just and sustainable model of global health financing must begin with stronger domestic commitment. The principles laid out by WHO Council on the Economics of Health for All should be adopted to produce a radical shift in how health is perceived and funded[18]. Governments should increase fiscal space by reversing austerity policies, using monetary tools to direct credit to health, and implementing strategic procurement policies. To enable this transition, international financial institutions should support debt relief, reallocate special drawing rights to health investment, and coordinate a fair global minimum corporate tax.

Adopt a fairer international finance architecture

Domestic investment is essential, but countries cannot succeed alone. A meaningful shift in global health financing also requires a fairer international finance architecture. The Bridgetown Initiative[19] outlines key reforms to achieve this: giving low- and middle-income countries a stronger voice in the governance of international financial institutions; improving and accelerating debt restructuring through a reformed G20 Common Framework; and revising debt sustainability assessments to account for climate and social investments as drivers of long-term growth. It also calls for expanded access to concessional financing based on vulnerability, not just income, and new sources of progressive global taxation, including on carbon emissions and fossil fuel windfalls.

Establish Regional Health Funds

WHO should call on major global health funds, such as GAVI and the Global Fund, to develop 5-year transition plans that gradually integrate their operations and funding flows into regional funds. By anchoring these resources within regions where political ties and institutional trust are stronger, the funds could be more likely to align with local priorities, strengthen accountability, and achieve greater long-term sustainability. These plans should include clear milestones for shifting decision-making authority and financial governance to regional bodies.

One promising approach to raise additional revenue is the use of earmarked corporate and sin taxes, such as levies on tobacco, alcohol, ultra processed foods, and extractive industries, to fund regional health priorities. When coordinated across countries, these taxes can both reduce harmful commercial determinants of health and generate stable funding for regional public goods.

To manage these resources effectively, countries should establish or expand regional funds that pool financing from multiple sources, including climate finance, philanthropic contributions, and innovative financing instruments. These funds should be governed by regionally anchored institutions with transparent rules, equitable representation, and formal participation from civil society and public health institutes. Mechanisms for shared revenue and accountable allocation would strengthen the legitimacy and autonomy of regional health governance, reduce reliance on external aid, and support a transition toward more equitable and self-determined financing systems.

The Global South should guide the redesign

Global donors should commit to funding a time-bound global taskforce charged with guiding the redesign of the global health architecture. This taskforce must be composed primarily of leaders from low- and middle-income countries to ensure that the process reflects diverse perspectives and lived realities. Its core role would be to safeguard alignment with the agreed principles and moral purpose of the new architecture—centred on health justice, equity, and shared accountability—while laying the groundwork for lasting structural reform.

A pathway to rebalance power and advance health justice in LAC

To contribute meaningfully to a renewed global health architecture, the Latin America and Caribbean (LAC) region must pursue a strategic shift. The following pathway outlines four priority changes needed to advance health justice and rebalance power in the region.

1. Re-design PAHO to strengthen regional capacity

To meet the evolving health needs of the Americas, PAHO should be restructured into a more focused and nimble institution. Its core functions should centre on leading the development of regional standards and regional public goods for health, coordinating regional and global responses during emergencies, and tracking both country priorities and regional progress. PAHO should gradually phase out its current portfolio of technical programs and embed these functions within existing national and regional institutions, particularly universities and research centres.

This approach would enhance relevance, build sustainable local capacity, and reduce duplication, while allowing PAHO to focus on its unique normative and convening functions. By repositioning itself as a strategic coordinator and enabler of regional expertise, PAHO can better support a future-oriented, decentralized global health architecture. Finally, relocating its headquarters to a LAC country should be considered to reduce operational costs and lead to a shift in the training and expertise of both PAHO staff and external collaborators, enabling more relevant contributions to the region.

2. Establish the Regional Public Health Centre for Latin America and the Caribbean (CRESALC)

The need to strengthen regional collaboration in Latin America and the Caribbean has been widely acknowledged, including in a recent Lancet call for the creation of a Latin American Centre for Disease Control and Prevention (LATAM-CDC)[20]. This call is important; however, the region would benefit more from an institution with a broader mandate. Therefore, I propose the creation of a Regional Public Health Centre for Latin America and the Caribbean (CRESALC), which would integrate key functions of a LATAM-CDC, such as surveillance, workforce training, and emergency response. Also, the CRESALC could function as an implementing partner of PAHO: facilitating technical cooperation across countries, supporting national implementation efforts, and generating actionable knowledge on regional research and policy priorities.

The governance of the agency would be in hands of a multistakeholder board composed of LAC member states, with guaranteed representation for smaller countries. Advisory participation would be open to public health institutes, academic networks, and civil society organizations to ensure transparency and equity.

To guarantee its funding, I propose a mix of regional public contributions, multilateral support from institutions such as CAF (Development Bank of Latin America) and the IADB, and catalytic investments from philanthropic actors. The agency should also be able to receive and manage pooled resources, issue grants and contracts, and mobilize additional financing for regional priorities, under clear safeguards to prevent conflicts of interest.

This model would allow the region to address both immediate threats and long-term capacity gaps through a coordinated, equity-driven, and context-responsive platform.

3. Launch the LAC Health Justice Knowledge Atlas

The Regional Centre CRESALC should launch a comprehensive consultation process that culminates in the creation of the *LAC Health Justice Knowledge Atlas.* This shared, AI-enhanced analytical tool will map health needs, health systems performance data, funding flows, and power dynamics, serving as the evidence base for collective decision-making and a compass for future reforms.

The “Knowledge Atlas” will be a living, evolving resource that helps actors see the whole system and co-design more coherent, evidence-based reform pathways. Intelligence should not replace political negotiation, but enable it to be smarter, more transparent, and more responsive to real needs.

The Atlas will also create and keep an up-to-date transparent registry of country defined needs to guide funding and share with PAHO and global health donors. Seed funding for the Atlas could be obtained from global philanthropic organizations or from multilateral financial institutions.

4. Establish the LAC Health Justice Fund

A major challenge to building a global health architecture grounded in regional solidarity is the lack of broad-based support for health justice. In many Latin American and Caribbean countries, political shifts, particularly the rise of right-wing populism, have weakened collective commitments and reframed structural fairness as an obstacle to individual merit and self-reliance.

To overcome this, I propose The LAC Health Justice Fund as a regional financing mechanism to support long-term, cross-border health priorities that individual countries cannot address alone regarding social and commercial determinants of health.

Grounded in principles of justice and fairness, it would complement national budgets by targeting shared structural challenges, particularly those affecting the most disadvantaged. The Fund would prioritise investments that ensure the fair distribution of the socially controllable factors that affect health.

Table 1 presents some possible actions that the LAC Health Justice Fund could take, how the funds would be governed, and possible strategic impacts in advancing health justice in LA.

Table 1. LAC health justice fund overview

Fair and Inclusive Financing	Governance Rooted in Justice	Strategic Impacts
Tiered regional contributions based on economic capacity allow all countries to participate without overburdening those with fewer resources.	Regional multistakeholder board with representation from national governments (rotated by income and size), civil society, Indigenous and Afro-descendant groups, health workers, public health experts, and ethicists.	Shifts power toward regional decision-making and shared responsibility.
Solidarity financing from high-income countries and philanthropies, governed by regional priorities rather than donor agendas. Global institutions allocate resources to the fund instead of individual countries or programs.	Decision-making guided by regional and country priorities and inclusion.	Serves as a model for equitable and justice-oriented health financing.
Corporate and regional sin taxes on products that harm public health—such as sugar-sweetened beverages, ultra-processed foods, alcohol, and tobacco. Revenues from these taxes should be earmarked for investments that advance health justice.	Participatory budgeting, open audits, public dashboards, and mechanisms for community feedback and redress. Coordination with PAHO, and subregional organizations.	Demonstrates that solidarity is not rhetoric, but a practical foundation for global health equity.

One feasible option is to structure the LAC Health Justice Fund through a regional public development bank, such as CAF. In this model, the bank would serve as the financial custodian, while strategic direction and priority setting would be led by a regional health governance body. This approach offers strong financial management capacity, established fiduciary systems, and the potential to attract additional co-investment. However, it carries the risk of technocratic dominance and would require clear safeguards to ensure that equity and public health goals remain central.

To reduce this risk, it could follow a model similar to that of the Global Fund, which works through financial intermediaries while retaining strategic oversight elsewhere.

To ensure that regional country priorities—not external interests—drive the agenda, all funding decisions would be evidence-based and aligned with values drawn from the LAC Health Justice Knowledge Atlas.

From challenge to action: a roadmap for structural transformation

Table 2. A roadmap for structural transformation

Challenge	Solutions	Who Needs to Act and How
Ethical and Political: Lack of fairness and justice in global health; and power concentrated on a few actors	Adopt fairness as a guiding principle of the redesign of institutions and practices of the new global health architecture and finance architecture. Redistribute power and resources.	**Countries** – Prioritize the needs of the most vulnerable populations. Demand a fair finance architecture to expand domestic health investment. Redirect spending toward structural determinants of health, including housing, education, food systems, and climate resilience. **LAC Countries** – Support the establishment of the LAC Health Justice Fund and CRESALC. **Regional Global Health Leaders** – Establish or strengthen regional institutions to coordinate health policy and financing. Convene and support South–South coalitions to share evidence and strategies for dismantling exclusionary systems. **Academia and Civil Society** – Develop and track indicators to monitor progress toward health justice. **Multilateral Financial Organizations** – Include LMICs representatives in governance. Expand debt relief, concessional lending, and global tax mechanisms to create fiscal space for equity-oriented investments. Adopt the Bridgetown Initiative principles for a fairer financial architecture. **Global Health Donors** – Allocate resources directly to the LAC Health Justice Fund rather than individual projects, enabling countries to influence spending decisions. Support the transition from global to regional funding mechanisms. Fund long-term institutional capacity building in the Global South. **WHO** – Advocate for fair rules for LMICs, particularly on cross-sectoral influences such as trade. Promote adoption of the WHO Council on Economics for Health for All principles.
Technical and Delivery: Fragmented, donor-driven systems; lack of effectiveness	Redesign organizations to avoid fragmentation. Build regional and national capacity. Harness digital tools and AI to assess and report on the degree of alignment between country-defined priorities and global funding flows.	**Countries** – Align national health plans with regional frameworks to reduce duplication and ensure long-term capacity building. **LAC Countries** – Support the establishment of the LAC Health Justice Knowledge Atlas. **Regional Institutions** – Maintain and publish a transparent registry of health needs and equity gaps to guide funding. **In LAC**: Host the LAC Health Justice Knowledge Atlas as the central data and analytics platform to guide resource allocation, monitor impact, and identify emerging risks. **Multilateral Financial Organizations** – Finance infrastructure and workforce for sustained regionally managed delivery systems rather than fragmented project pipelines. **Global Health Actors** – Provide technical assistance only when anchored in regional and national institutions, with clear timelines for capacity transfer. **WHO** – Refocus its mandate on three core global functions: setting norms and standards, providing independent monitoring and accountability, and coordinating health emergencies. **WHO Regional Offices** – Become nimble and focus on building national institutional capacity. Support governments in aligning donor investments with these priorities and in resisting duplicative or misaligned initiatives. Monitor Lusaka Agenda commitments.

Conclusion

This proposal puts forward a bold vision for a new global health architecture. It is grounded in country and regional leadership, backed by stronger domestic investment, and supported by a fairer international financial system. To make this vision possible, global governance and finance must be guided by fair rules that give all countries the power and resources to advance health justice. This proposal advances a structural shift away from a donor-dominated model toward a distributed system built on country and regional leadership, shared responsibility, and health justice.

Yet ambition must be grounded in realism. Shifting to regional governance carries risks. Persistent disparities in fiscal capacity, institutional strength, and political stability across countries could reinforce existing hierarchies unless mechanisms for accountability, equitable representation, and regional solidarity are built from the start. A new architecture must not only redistribute power but ensure it is used with fairness, inclusion, and a commitment to advancing health for all.

Lasting transformation will require more than bold ideas. It demands deliberate and sustained action to convene regional leaders, foster coalitions of trust, and revamp institutions that are capable, representative, and responsive. The task is urgent. Now is the time to design, align, and act while there is still an opportunity to shape a post-SDG global health system. If countries and regions move forward together, a more just, effective, and resilient global health order is within reach.

Endnotes

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