# A Proposal for Transforming the Global Health Architecture

## by Kelley Lee
### With contributions from Julianne Piper and Miranda Nonis

## A Perspective from the Europe and North America 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

Current institutional arrangements for global health have evolved over time in an ad hoc and *laissez faire* manner. The result is akin to a highly prized, but poorly planned town blighted by inequities, partially constructed buildings, haphazardly distributed infrastructure, an insecure funding base, and fragmented governance. As such, there is no global health "architecture" in a strict sense. The US withdrawal from global health leadership, as the lead financier and most influential resident of this town, has now threatened its continued viability. At the same time, this severe disruption offers remaining residents a valuable opportunity to address longstanding problems in the town's overall design. We thus approach this exercise as an opportunity to transform the institutional arrangements underpinning global health.

Departing from repeated calls for reforms that tinker with individual global health organizations, this paper proposes innovations to transform the institutions, products and processes that advance global health cooperation. To encourage critical reflection, our proposal is intentionally provocative. We ask the global community to consider what would comprise a global health architecture built in a deliberate and planned way. Side-stepping a tendency to oscillate between an infeasible "to do" list and narrow donor-driven shortlists, we propose a global health architecture that aligns with a world in which human health is shaped by planetary interconnectedness, requires complex systems thinking, and best advanced by prioritising equity.

We propose that transforming the global health architecture begins with good building practices. This requires an agreed design brief that sets out a clear-minded assessment of current systemic shortcomings and then what is needed (what we mean by global health). Innovation design thinking then provides the lens for developing proposals for transformative change. *Institutional innovation* aims to align the global health architecture with the emerging new world order and priority needs. We propose WHO and existing global health initiatives be consolidated, rationalized and supplemented to form a network-based **Global Health Nexus (GHN)**. Under the technical and normative leadership of a 12-member **Stewards Council**, governed by a **Global Health Organization (GHO)** comprising a Constituents Assembly, **Executive Board**, and **Scientific Board**, and administered through six Hubs, we argue that this new architecture is more connected, agile and responsive.

*Product innovation* identifies six core functions that are essential for collective global health action. Rather than chronically struggling to do "everything, everywhere, all at once" with thinly spread resources, we propose a sustainable system that delivers selected core functions to benefit all countries. Delivering these core functions to a high standard, functions that would not or cannot be provided by individual countries acting alone, public trust in global health institutions would also be rebuilt.

*Process innovations* set out transformative ways of representation and decision making, that harness the diverse actors that contribute to global health, and of increasing transparency, accountability and public trust in global health processes.

We conclude with pathways to transform the global health architecture over 24 months, from a poorly planned town with haphazard buildings, infrastructure, governance and financing, to a well-designed and run community with shared benefits for all citizens. The pathways entail a Global Declaration on the Rebuilding of the Global Health Architecture; public engagement and consultation plan; appointment and convening of the Global Health Stewards Council to put for a draft design; form a Founders Circle to provide transitional and develop long-term financing arrangements; appoint a Technical Preparatory Committee to draft legal and technical documents for the new design; and hold a Global Health Summit to agree the new plan and adopt the founding documents.

# 1.0 Introduction

## Global health institution building in the 21st century

*"When you press the pause button on a machine, it stops. But when you press the pause button on human beings they start — start to reflect, rethink assumptions, and reimagine a better path."[1]*

The recent abrupt end, to what has been described as a "golden age" of global health funding, has thrown the entire system into turmoil. Yet numerous past attempts at reform point to longstanding need for change.[2-5] Since 2000, there have been four World Health Organization (WHO) reform agendas; 17 high-level expert groups to improve global responses to major disease events;[6,7] at least 10 independent commissions on varied global health issues;[8] and a multitude of new financing mechanisms, funds, and multistakeholder partnerships.[9,10] The COVID-19 pandemic reaffirmed the critical importance of global health governance but stress-tested existing institutions. Public confidence in government, public health and even science has subsequently declined.[11,12]

While misinformation and populist rhetoric contributed to this trend,[13] deeper self-reflection and systemic change are overdue. Since the 1990s, donor-driven institution building for global health[14] has evolved without an overarching vision or strategic design. The functions carried out within this *laissez faire* system have been too often uncoordinated and unsupported by sustained funding. Constant uncertainty, short termism, and institutional memory loss have left global health subject to political cycles[15,16] What is often called the "global health architecture" bears little resemblance to what the term means – an organized or integrated system of institutional components with distinct functions.

We liken global health to a town that has sprung up piecemeal over time as resources permit. Alongside abandoned lots and modest dwellings, there are opulent buildings. Each fabrication has its own architectural style, reflecting available resources and personal taste. Without a central planning office, this town might have four hospitals but no sewage plant or fire station. Public roads and transport systems might connect to some but not all parts of the town. Importantly, there is not one recognized governing authority but multiple authorities governing specific parts of the town. This means no central taxation system. Some public services are paid by membership fees while others rely on donations. How resources are allocated for what purposes thus varies. It is unclear, for instance, who has the authority, responsibility and capacities to address urgent or important needs as they arise.

This analogy of a poorly planned and functioning town is applied in this paper to propose ideas for building the missing architecture for global health. Rather than more reforms, which merely tinker at existing institutions, a "back to the drawing board" approach is urgently needed. Guided by "good building practices," first, we set out the "design brief" for what we are building. What do we mean by global health cooperation? What are the design principles that will guide our thinking? Second, we set out the proposed design focusing on institutional, product and process innovation. While we cannot set out detailed building plans, we aim to challenge outdated assumptions and provoke new thinking. Third, the pathways for advancing transformative change through practical steps are described.

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[I] Good building practices encompass a techniques and methodologies to ensure buildings are safe, durable, sustainable, and efficient. (i.e. optimizing design, material selection, construction methods to create high-quality structures which meet occupants' needs while minimizing environmental impact.

[II] A design brief is a document outlining a client's requirements for a construction project, forming the basis for the design phase. Essentially, it's the client's instructions to the design and construction team, ensuring everyone is on the same page in terms the project's purpose, scope, and desired outcomes.

# 2.0 The design brief

## 2.1 A rethinking of what we mean by "global health" cooperation

The sprawling nature of global health activities is the product of poorly defined boundaries yet an agreed definition has been notoriously difficult to produce.[17] The imperialist origins of health cooperation, known over time as tropical medicine and international health, have conflated global health with health development.[18] This dominant framing persists despite efforts to decolonize global health as donor-defined, geographically nonsensical, and structurally unjust.[19] Moreover, global health as development feeds public perceptions that funding is essentially charitable and thus discretionary.[20] The equating of global health with the needs of low- and middle-income country (LMICs) also underplays the universality of key drivers of health outcomes in an interconnected world (e.g. environmental change, trade and investment, illicit activities, population movements).[21,22] At the same time, global health cannot mean all health issues in all countries, otherwise this would simply be "health."[23]

Global health cooperation must thus be defined as neither an infeasible "to do" list or donor-controlled shortlist.[24,25] Any architecture would struggle to fulfill its mandate without clear boundaries delineating what's in and what's out.[26] As a conversation starter, we apply a recent definition that emphasises interconnectedness, systems thinking and equity. Global health concerns:

> the interconnected physical, mental, social and ecological well-being of individuals, communities, and populations across the world. Global health concerns the intricate relationships between human, animal and planetary health, and the need to address inequities and disparities that arise from the intersection of economic, environmental and social factors.[27]

## 2.2 Innovation thinking as a design principle

In the business world, a distinction is drawn between *improvement* to existing products and processes, and innovation which is "something truly different...that makes customers' lives better."[28] The pressure on firms to innovate is ever present but has been especially acute since the mid twentieth century. Only six of the 25 leading Fortune 500 companies in 1961 remain on the list today. The average life expectancy of Fortune 500 companies has declined, from 75 years then to less than fifteen years today.[29] We argue that public institutions must similarly evolve as needs and circumstances change.[30] Public sector innovation is especially important today given the close link between public trust in government and the effective delivery of public services.[31]

We propose three types of innovation to transform global health cooperation. *Institutional innovation* concerns the "business model" by which an organization delivers its product or function.[32] How can we restructure to optimize collective action for health worldwide? *Product innovation* creates new products or significantly improves existing ones. What should be the core functions of a global health architecture? *Process innovation* improves how products or functions are created and delivered through, for instance, new technologies, improved workflows, or secure supply chains.[33] How might agreed core functions in global health be delivered more efficiency, effectively and impactfully.

# 3.0 The design

## 3.1 Institutional innovation: How might the global health architecture be restructured?

Many reforms have been proposed to date to WHO's mandate, programmes and activities, akin to plugging more peripherals into an ageing computer.[34] The proliferation of global health initiatives that emerged from the late 1990s was, in part, a response to dissatisfaction with the scope and pace of these reforms.[35,36] While further reforms and initiatives may advance incremental improvements, the world has changed more rapidly. Globalization has fundamentally altered how societies are organized and connected; what frequency and speed crossborder flows occur; and what collective action problems arise from this interconnectedness. Chronic challenges in global health cooperation, and the severe disruption we currently face, support the need to leapfrog to an innovative institutional design that is more connected, agile and responsive to evolving needs, what Hagel calls the "big shift".[37]

We propose transforming the poorly planned town into a **Global Health Nexus (GHN)** which describes the entirety of stakeholders,

(Figure 1). The GHN would be normatively guided by an independent **Stewards Council** and operationally led by a **Global Health Organization (GHO)**. The GHO would comprise a *Constituents Assembly* (plenary of state and non-state actors), *Executive Board* (EB) (heads of six hubs) and *Scientific Board* (independent interdisciplinary subject-matter experts). Implementation of GHO decisions would be through six hubs, each responsible for an agreed core function (see Section 3.2 for details) rather than content area (e.g., communicable diseases). The lead for each hub (e.g., Chief Financial Officer, Chief Operating Officer) would operate according to agreed norms and standards for that domain. For example, the Knowledge Hub would be governed by recognised scientific principles and methods to ensure quality and independence (e.g., peer review, declaration of interests). Hubs would be geographically distributed, located where there is a concentrated supply of or demand for specialist expertise or resources. To reduce costs, hubs would be based in lower-cost settings and supported by technology to ensure connectivity and accessibility.[38]

A key responsibility of the Stewards Council would be to use an inventory of knowledge about existing global health institutions, resources and capacities to disassemble, rationalise, consolidate, and reassemble parts of existing institutions best aligned with the agreed core functions. The aim is to recruit and repurpose essential expertise,

experience, capacities and resources in ways that reduce redundancies and optimize assets. Staffing would be right-sized and retooled to focus on the delivery of core functions. For example, UNITAID expertise in mobilizing and allocating funds through innovative financing mechanisms would be redeployed as part of the Financing Hub. GAVI, the Vaccine Initiative brings strong expertise for the work of the Technical Cooperation Hub. WHO scientific networks and review processes would be harnessed to support the Scientific Board. Different regional health organizations would bring valuable insights and experiences across several hubs including Stewardship and Security, Compliance and Accountability, and Technical Cooperation. Gaps in existing capacities would then be identified and filled.

As an interconnected network, the GHN would discourage silos and encourage integration, collaboration and adaptability. Combining multi-agent shared governance (i.e. the GHO) with autonomous strategic leadership (i.e., Stewards Council), the GHN would balance democratic representation, effective public administration, and mechanisms for independent strategic oversight. This structure aims to minimise problematic conflicts of interest and political partisanship. By including state and non-state members, these institutional arrangements recognise that collective solutions to many global health needs require cross-sectoral engagement and cooperation including commercial and/or public-private actors. Acknowledging understandable concerns about some forms of private sector engagement in global health cooperation, strong adherence to sound public governance principles would be essential to protect public interests and prevent moral or ethical compromise. Further details on governance is described in Section 3.3.

The GHN would also transform global health financing. Most innovative financing mechanisms to date do not offer sustained funding for public goods which are, by definition, market failures.[39] Applying market logic to fund them overlooks the fundamental difference between public administration and corporate governance. Returning to our analogy of a poorly planned town, creative fundraising could finance a special initiative but insufficient to sustain basic public services such as waste management. National governments have citizens and a tax base for this purpose. Arguably, the health and well-being of all populations are also dependent on global health core functions and should thus be funded accordingly.

We propose financing innovations that generate income through a broader membership system, while reducing operating costs through streamlined operations. Secure income and cost savings would partially address current funding shortfalls.[40,41] Annual membership fees (tiered by income and population) and global taxation, rather than discretionary contributions, would provide sustained financing. All funds would be centrally pooled for allocation by the GHN. Taxation is the main source of funding for key public services in all countries.[42] The idea of a global tax regime - the Tobin Tax on foreign exchange[43] and Robin Hood Tax on financial investments[44]- have not gained sufficient political support previously because of perceived infringements on state sovereignty.[45] Yet the airline ticket levy to fund drugs for HIV/AIDS, tuberculosis and malaria drugs has been successfully implemented given recognition of shared benefits. It is timely to revisit global taxation

models. For example, the GHN could be funded with a small percentage of transactions that unfairly avoid national tax systems such as digital services.[46] The rationale for doing include enabling the GHN to carry out core functions that, for example, reduce the impacts of costly health emergencies. The cost to the world economy from COVID-19 was around US$82 trillion.[47] The proposed taxation system could also be embedded in the GHN's membership model. For example, member states could commit to a nominal 0.01% allocation from alcohol or tobacco taxation in exchange for reduced membership fees. Additional income could come from the commercialization of selected GHO goods and services akin to publicly governed profit-making enterprises.[48] Government business- or state-owned enterprises,[49,50] sovereign funds and crown corporations, for example, all generate significant and sustained government revenues.

Figure 1: Global Health Nexus



Source: Graphic created by Gladys We, August 2025.

## 3.2 Product innovation: What core functions should be carried out?

Previous global health product innovations have focused on new technologies, financing mechanisms (e.g., Pandemic Bonds),[51,52] and public-private partnership such as CEPI and COVAX.[53] Beyond technological innovation and issue-specific health financing, transformation requires reflecting critically on what the core functions of the global health architecture should be.

To address the imperfect patchwork of functions carried out in a poorly planned town, we propose that the new global health architecture focus on a finite set of core functions as its "north star" (overarching strategic vision or goal).[54] These core functions would align with a definition of global health with clearly delineated boundaries (Section 2.1), and be focused on enabling collective action and shared responsibility in an interconnected world. As global public goods, used in a broad sense, these are core functions that individual actors would not or could not produce alone as efficiently or effectively. At a time of austerity, these functions might be limited to those likely to deliver the most health gains worldwide. We propose a set of core functions as an initial starting point in Table 1.

**Table 1: Proposed core functions of the global health nexus**

| Core function | Description | Global public good |
|---|---|---|
| Convening and coordinating (Constituents Assembly). | • Assembling interested parties for deliberation, consensus-building, conflict resolution, and priority-setting<br>• Providing mechanism for logistics and operations planning | Norms and standards<br>Global Declarations<br>Strategic priorities and action plans<br>Legal and regulatory frameworks |
| Convening and coordinating (Constituents Assembly) | • Mobilising and allocating resources<br>• Budgeting and financial reporting | Pooled resources<br>Financing mechanisms<br>Financial reports. |
| Gathering, generating, synthesizing and applying knowledge (Knowledge and Data Hub) | • Synthesising and reporting on data across populations and countries<br>• Facilitating application of evolving evidence<br>• Monitoring and reporting on current state of knowledge | Datasets<br>Surveillance, monitoring and reporting<br>Evidence syntheses<br>Research and development<br>Guidelines and protocols<br>State of the World reports |
| Protecting common resources and managing crossborder externalities (Stewardship and Security Hub) | • Protecting common resources that are vital to human, animal and planetary health<br>• Preventing, identifying and remedying health threats arising from crossborder factors | Monitoring & evaluation reports<br>Alert system<br>Risk assessments<br>Legal and regulatory frameworks<br>Dispute settlement<br>Compensation mechanisms |
| Maintaining public support and trust (Public Engagement and Communications Hub) | • Informing the public about achievement of core functions and finances<br>• Maintaining public transparency and accountability<br>• Supporting public understanding of science and evidence<br>• Consulting with priority populations | Annual reports<br>Public information<br>Public engagement |
| Capacity building and support (Technical Cooperation Hub) | • Supporting minimum capacities<br>• Lesson learning across jurisdictions | Knowledge exchange<br>Training programmes |
| Overseeing and evaluating activities and impacts (Compliance and Accountability Hub) | • Supporting the GHN as a learning organization<br>• Upholding transparency and accountability<br>• Ensuring compliance with core values, ethical standards and agreed procedures<br>• Conducting summative, outcome, process and other types of evaluation | Monitoring and evaluation reports<br>End of project reviews<br>Professional development resources |

By consolidating core functions currently distributed across a fragmented ecosystem, the GHN would improve efficiency, effectiveness, and impact. The combined operating costs of WHO, the Global Fund, GAVI and the Pandemic Fund alone totalled over US$450 million.

Streamlining and reducing duplication would lower overall costs and enhance coordination. For example, the GHN would facilitate centralized procurement and bargaining power for competitive purchasing agreement for essential goods and services.

## 3.3 Process innovation: How can we transform the delivery of core functions?

The messiness of current global health governance, like a town with no elected mayor or single governing council, has been highly problematic. Many others have no voice. Transformative change is needed to ensure that who holds authority, and how authority is exercised, supports the delivery of core functions. The new architecture must also align closely with good governance principles in ways that rebuild and maintain public trust.

### 3.3.1 Reconfiguring representation and decision-making power

Many initiatives are supporting diversity of participation and leadership in global health such as Global 50/50,[55] Global Health Corps,[56] WomenLiftHealth,[57] and Emerging Voices for Global Health.[58] Representation concerns the extent a decision-making body reflects the population it serves. It also relates to the competence, authority and autonomy of actors involved in decision-making processes on behalf of others. Autonomy means representatives are enabled and obligated to make decisions that are in the best interests of those they represent. Authority is externally validated, legitimate power to determine, control or enforce the actions of others. In global health, the autonomy and authority of various decision-making bodies or their members is often unclear. For example, member states are elected to hold a seat in the WHO Executive Board, each then selecting a technically qualified individual to, in principle, serve in an individual capacity. Similarly, many GHI boards comprise employees of other GHIs, public-private partnerships (PPPs), corporations and/or philanthropic foundations. In addition to lacking diversity, the governance of these boards can be weakened by a lack of independence, autonomy or authority.

The Stewards Council is proposed as an independent "Board of Governors" with sufficiently autonomous authority at the most senior level to effectively steer an overarching global health strategy. We propose that the Stewards be elected by the GHO Constituents Assembly to serve set terms in an individual capacity. As a Council, Stewards are responsible for advancing collective interests and agreed outcomes of global health benefit. Plenary deliberations of the Constituents Assembly would then agree network priorities and guide the resourcing of GHO and Hub actors and activities. The independent Stewards Council thus supersedes the authority of the Constituents Assembly only where necessary to propel the GHN together towards a shared vision and common mission for global health. To effectively direct GHN strategy and impact, the Stewards Council requires sufficient institutional authority to take executive decisions when needed. Importantly, this authority must be sufficiently insulated from personal, organizational or national interests.

Another proposed innovation to strengthen representation is the Constituents Assembly which departs from state- and donor-centric agenda-setting that currently dominates. Its detailed composition would require initial consultation and deliberation (see below). The broad parameters of the Assembly would include a limited size (e.g., 50 seats), drawn from a broader membership. The seats would be allocated across diverse types of global health actors, including member states, regional unions/organizations, civil society, private sector, and scientific community. Seats would be allocated according to prioritized demographic and societal distributions, with state-based seats allocated to ensure representation by factors such as income-level, geographical region, relative burden of diseases etc. Within each category, seats would be assigned from a qualified pool of nominees through a random lottery system. Triennial terms and staggered seat rotations would ensure consistent opportunities for diverse representation while fostering continuity of institutional knowledge and practices.

### 3.3.2 Strengthening transparency, accountability and public trust

Currently, transparency and thus accountability is often obscured in global health by complex and overlapping domains of decision-making and operations.[59] No one should require a medical education or PhD to understand why well-functioning and appropriately funded global health cooperation is essential to everyone's health and well-being. To foster public confidence and trust in global health cooperation,[60] roles, responsibilities and accountability mechanisms are needed across a new global health architecture.

In recent years, GHI TORs, governance and appointment mechanisms have been made more publicly available. However, beyond high-level documents, there is limited explanation of the inner-workings and decision-making processes of global health actors.[61] One example of a "black box" in global health is how and what expertise and evidence are prioritized or privileged within GHIs. This is simultaneously a technical and political process, with power bestowed to shape and inform technical guidelines and standards, "best" practices, and received scientific knowledge globally. Improved transparency and accountability of such processes is critical. This includes

the need to improve the quality of political processes as central to effective global health cooperation (notably the core function of convening), rather than a blight to be removed. We propose the GHN foster a culture of openness through a multifaceted approach to transparent communication about decision-making processes, data sharing, and public engagement. The "plugged in" world of today demands greater attention to transparency and accountability by all public institutions. Here we propose general principles and components for change, to provoke conversation, but recognise that detailed configurations, rules and responsibilities need careful deliberation.

Key innovations include the establishment of a Scientific Board (SB), that operates independently from both the Executive Board (EB) and Constituents Assembly, to support the six hubs based on needs and competencies. The SB would serve as the focal point for engaging the global health research community. SB representation would ensure a broad range of disciplines, sectors and geographically defined competencies. SB seats, led by a Chief Scientific Officer, would be allocated by a two-fold process. First, nominations would be solicited from across the GHN, possibly requiring endorsement from the Hubs and Constituents Assembly. The Stewards Council would then be responsible for selecting and appointing SB members from nominees. Instead of donor-led priority setting, the SB would peer-review GHN work programs and budget requests. This would ensure proposed activities have a clear scientific and policy rationale, align with available evidence, identify clear impacts, and adhere to recognized ethical standards.

A Chief Executive Officer (CEO) would lead the GHO and be responsible for high-level operational and administrative leadership. Rather than an elected position akin to the WHO Director-General, the CEO would be determined through a competitive hiring process, subject to approval and confirmation by the Constituents Assembly and Stewards Council respectively. Qualified candidates would be initially vetted by a hiring committee composed of representatives from GHN Hubs, the SB, the Stewards Council and the General Membership. A shortlisted pool would then advance for consideration and election by the Constituents Assembly. The preferred candidate would then be nominated to the Stewards Council for final confirmation. The fixed term CEO position would include a standing seat on the Stewards Council. The EB would be composed of the CEO, heads of each hub, and key representatives from different GHN arms. In additional to representatives from the SB, Constituents Assembly and

possibly general membership, the EB would include a competitively appointed Chief Financial Officer, Chief Operations Officer, Chief Data Officer etc.

On financing, the GHN would seek to reduce expenditure and increase revenue related to processes. Successful firms with international operations, for example, seek to locate offices and staff in lower cost settings. Head offices are sometimes situated in unexpected locations, based on tax incentives and lower living costs. Currently, WHO headquarters, most GHIs, and international NGOs are primarily located in some of the world's most expensive cities. Our proposed GHN model hinges on hybrid working arrangements and a decentralized system of network Hubs. Aside from a minimal HQ location if needed, Hubs can be located regionally, and larger nexus convenings (e.g. Constituents Assembly, events for general members, high-level summits etc.) would be hosted on a representative rotating basis, hosted by a GHN member selected through a competitive bidding mechanism, similar to the International Olympic Committee (IOC) and other multilateral summits such as the G7 and G20. An operational commitment to limited in-person participation for proximate members and the regular use of integrated hybrid meetings would generate significant cost savings. For example, in-person Pandemic Treaty negotiations in Geneva cost around US$200 million.[62]

Innovations to improve equitable access and participation would include funding mechanisms for convening costs. Regular GHO and GHN meeting costs would be budgeted and covered through scaled membership fee distributions. For ad-hoc or exceptional convening needs, the EB would establish a process where participants submit projected participation costs (e.g. time, travel, meeting supplies, etc.). The cumulative costs would then be transparently averaged and distributed using a sliding income-adjusted scale. Finally, process innovations to improve accountability could be reinforced by performance- or compliance-based adjustments to GHO taxation rates. Where multilateral enforcement mechanisms have repeatedly failed to ensure national compliance with global commitments, a progress reporting system that links participation to reduced financial obligations would incentivize GHN members to implement agreed commitments. Such processes would necessarily include adjustments to account for extenuating circumstances and different capacities and resources among members.

# 4.0 Recommended pathways for transformative change

The evolution of global health institutions, in the absence of an overall design logic to guide institutional building, has skewed membership, core functions, governance, financing, and infrastructure. Reforms that tinker with selected aspects of single organizations that operate largely independently, without addressing the need for an overall redesign, will lead to limited improvements. Indeed, with the sharp cut in US funding, we argue that business as usual is no longer an option. We propose the following key steps to building a new global health architecture.

## 4.1 Global declaration on building a new global health architecture (months 1-6)

Building on efforts to date, including those advanced by The Wellcome Trust (WT), an Expert Group would be formed to summarize existing evidence on the strengths and weaknesses of existing institutional arrangements for global health. An inventory of knowledge would be compiled to comprehensively maps existing institutions, resources and capacities, and any key gaps. This review, along with WT synthesis of five regional papers, would serve as the background documents for a summit of like-minded state and non-state actors committed to the rule of law, collective action, equity, solidarity, and other agreed norms and values.

A Global Declaration of commitment to build a new global health architecture would be drafted and shared. Importantly, the declaration would necessarily include recognition that reform of existing institutions cannot achieve the systemic changes needed, especially given the current volatility of the world order. A Global Declaration would set out agreed terminology and definitions, a vision for what is to be achieved, core principles, statements of fact or observation, and a clearly defined process for advancing change. A clear statement of the benefits from a reset, and the enormous costs of not doing so, should be included. This would serve as the roadmap for the next two years. The summit would initiate a global campaign to establish a Founders Circle of individuals and organizations committed to funding the next steps in the transformation process (see below). Finally, an inaugural, *pro tem* 12-member Stewards Council would be appointed to lead the process forward.

## 4.2 Advance founders circle (months 1-12)

The funding void created by the US withdrawal from global health leadership cannot be remedied by existing financing mechanisms. Voluntary contributions, in the form of extrabudgetary contributions, replenishments and development aid, may be a stopgap but do not address the need for sustained funding. The current financing system is also inefficient. Sharing the goal of transforming the global health architecture, the Founders Circle would fund the start-up of the GHN until agreed financing mechanisms are put into place. While unsuitable for long-term financing, during this period of austerity, start-up could draw upon varied sources such as charitable foundations, corporate donations, and even crowd funding. In addition to transition funding, the Founders Circle would be tasked with establishing the longer-term financing mechanisms for the GHN. As described, this would come from membership fees, global transaction taxes, voluntary contributions, and cost-recovery.

## 4.3 Public engagement and consultation (Months 1-24)

Following recognized principles and best practices,[63] public engagement and consultation would be undertaken alongside the drafting and endorsement of a global declaration. This includes defining clear goals and objectives, identifying and inviting diverse participants, utilizing accessible background materials and engagement modes (e.g., on-line or hard copy, written and oral), ensuring requests for input are clear (e.g., what do you think should be the core functions of a global health organization?), and communicating how submissions will inform decisions. Given recently declining public trust towards governments, big business and the wealthy[64] and the inclusion of WHO in this trend since the COVID-19 pandemic, worsened by misinformation narratives, consensus building in global health must go beyond national governments, and other powerful actors. Public trust is essential to the success of any global health governance system. Specific needs for conducting a global public consultation, such as the use of multiple languages, variable access to technology, and cultural differences, should be proactively addressed.

An important component of public engagement throughout the transformative change process would be consultation and gathered inputs from the many professional staff, scientists and policymakers that make up the current global health landscape. Transformative change that disregards or fails to build upon from the richness and breadth of existing knowledge and experience in global health would be unwise and potentially hindering to a successful transition. The essence of our proposal is to take stock, consolidate, reconfigure and streamline existing global health capacities in ways that creates structural coherence, operational integration, and targeted activities focused on core functions. Public engagement must therefore include meaningful engagement within and across the diverse global health community. A series of deliberative dialogues should be convened to facilitate productive conversations and mutual understanding on contentious issues.

## 4.4 Convene global health stewards council to design new architecture (months 7-12)

Once the Global Declaration is agreed, advancing the specific design must be actioned. This would be undertaken by a selected group of global health champions who are respected leaders with diverse and relevant experiences (e.g., scientific, diplomatic, legal). Historically, the most substantive changes to public institutions have come from the thought leadership and political courage of a few individuals or small groups. This is true for dramatic societal shifts including democratic transitions; great achievements of international solidarity; and many revolutionary technological and social innovations. Transformative change to the global health architecture would thus be led by such a group of exceptional individuals committed to prioritising the common good above individual interests. This group would serve as the pro tem Global Health Stewards Council which would: a) confirm agreed core functions; b) set out the GHN design including governance structure; and c) mobilize political support from key actors. To minimise conflicts of interest, members of the Global Health Stewards Council and Founders Circle would be precluded from serving on GHO governing bodies.

As discussed above, a key initial step for the Global Health Stewards Council would be using the inventory taken by the Expert Group (Section 4.1) to disassemble, rationalise, consolidate, and reassemble parts of existing global health institutions with the agreed core functions. Another early task for the Stewards Council would be to expand representation within the new global health architecture to

include both state and non-state actors, notably the private sector. The contemporary global health landscape comprises diverse public, private and hybrid actors. Setting aside longstanding debates about roles for private firms in global health, an architecture should encompass private sector actors as part of the global health landscape. At the same time, we caution that to be truly transformative, innovation cannot be equated with the selective provision of global public goods to align with private or corporate interests. Global public goods, by definition, are not profit-making, and therefore will not be produced through any amount of creative monetization or financialization of global health. Thus, to produce and sustain global public goods, we recommend the Stewards Council clearly delineate mechanisms to identify and mitigate potential conflict between private versus public interests across the proposed broadened membership.

## 4.5 Preparation of technical and legal framework documents (months 13-18)

After the design is agreed, a Technical Preparatory Committee (TPC) would be formed to support the Global Health Stewards Council in the drafting of founding documents. This would include a Constitution, defining the GHN's purpose, membership, and structure; and internal governance documents setting out rules of procedure, financial regulations, and staffing policies. These documents will form the basis of negotiations at the Global Health Summit.

## 4.6 Global health summit (months 19-24)

A high-level meeting would be convened during this period, attended by heads of state, ministers of health, and key global health stakeholders, to agree the establishment of the new GHN. The precedent is the International Health Conference convened in 1946 which met to create a single international health organization (WHO) to replace existing ones and address postwar health challenges. Deliberations would be guided by the work of the Global Health Stewards Council and Founding Circle. The key outcomes of the Summit would be:

- agreement and signing of the Constitution of the Global Health Nexus

- appointment of an Interim Commission to manage the transition to a new organization

- timeline for the transition process.

# Endnotes

1. Dov Seidman, CEO of LRN as quoted in Friedman T. Thank You for Being Late: *An Optimist's Guide to Thriving in the Age of Accelerations*. Farrar, Straus and Giroux, 2016.

2. Lee K. *The reform of the World Health Organization, A review of recent studies and initiatives*. Stockholm: Swedish International Development Cooperation Agency, 1997.

3. Lucas A, Mogedal S, Walt G, Hodne Steen S, Kruse SE, Lee K, Hawken L. *Cooperation for Health Development, The World Health Organisation's support to programmes at country level*. London: Governments of Australia, Canada, Italy, Norway, Sweden and UK, 1997.

4. Vaughan J, Mogedal S, Kruse SE, Lee K, Walt G, de Wilde K. Cooperation for *Health Development: Extrabudgetary funded in the World Health Organization Oslo*: Governments of Australia, Norway and UK, 1995

5. People's Health Movement. Agenda Item 16.1. *Strengthening the global architecture for health emergency prevention, preparedness, response and resilience*. WHA78 – PHM Policy Brief. https://phmovement.org/sites/default/files/2025-05/WHA78%20-%20PHM%20Policy%20brief%20.pdf

6. Gostin L, Tomori O, Wibulpolprasert S, Jha AK, Frenk J, Moon S, et al. Toward a Common Secure Future: Four Global Commissions in the Wake of Ebola. PLoS Medicine 2016; 13(5): e1002042.

7. The Independent Panel for Pandemic Preparedness and Response (IPPPR). (2021). *Covid-19: Make it the Last Pandemic*. https://theindependentpanel.org/main-report/

8. Ottersen O, Dasgupta J, Blouin C, et al., The political origins of health inequity: Prospects for change. *Lancet* 2014; 383(9917): 630–667. https://doi.org/10.1016/s0140-6736(13)62407-1

9. For example, see Gostin L, Friedman E, Finch A. The Global Health Architecture: Governance and International Institutions to Advance Population Health Worldwide. *Millbank Quarterly* 2023; 101(S1): 734-769; Marten R, Kadandale S, Nordström A, Smith R. (2018). Shifting global health governance towards the sustainable development goals. *Bulletin of the World Health Organization* 2018; 96(12), 798-798A. Smith R, Lee K. Global health governance: we need innovation not renovation. *BMJ Global Health* 2017; 2(2), e000275; Moon S, Sridhar D, Pate M. et al. Will Ebola change the game? Ten essential reforms before the next pandemic. The report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola. Lancet 2015; 386(10009), 2204–2221; and Fidler D. Architecture amidst anarchy: global health's quest for governance. Global Health Governance. 2007; 1.

10. IPPPR. *COVID-19: Make it the Last Pandemic*. Report of the Independent Panel for Pandemic Preparedness and Response, Geneva, 2021. https://theindependentpanel.org/mainreport/

11. Leslie J. The Crisis of Trust in Public Health. Think Global, 14 February 2023. https://www.thinkglobalhealth.org/article/crisis-trust-public-health

12. Guo C, Hu X, Yuan D, et al. The effect of COVID-19 on public confidence in the World Health Organization: a natural experiment among 40 countries. *Globalization and Health* 2022; 18: Article 77. https://doi.org/10.1186/s12992-022-00872-y

13. Wilson K, Halabi S, Gostin LO. The International Health Regulations (2005), the threat of populism and the COVID-19 pandemic. Globalization and Health 2020; 16(1): Article 70. https://doi.org/10.1186/s12992-020-00600-4

14. Hoffman S, Cole C. Defining the global health system and systematically mapping its network of actors. *Globalization and Health* 2018; 14: Article 38. https://doi.org/10.1186/s12992-018-0340-2

15. Smith SL, Shiffman J. Setting the global health agenda: The influence of advocates and ideas on political priority for maternal and newborn survival. *Social Science and Medicine* 2016; 166: 86–93. https://doi.org/10.1016/j.socscimed.2016.08.013

16. Witter S, Palmer N, Jouhaud R, et al. Understanding the political economy of reforming global health initiatives - insights from global and country levels. *Globalization and Health* 2025; 21(1): Article 40. https://doi.org/10.1186/s12992-025-01129-0

17. Garcia-Basteiro A, Abimbola S. The challenges of defining global health research. *BMJ Global Health* 2021; 6(12), e008169. https://doi.org/10.1136/bmjgh-2021-008169

18. Wenham C, Busby J, Youde J, Herten-Crabb A. From Imperialism to the "Golden Age" to the Great Lockdown: The Politics of Global Health Governance. *Annual Review of Political Science* 2023; 26: 431-450. https://doi.org/10.1146/annurev-polisci-052521-094633

19. Abimbola S, Pai M. Will global health survive its decolonisation? *Lancet*, 2020; 396(10263), 1627–1628. https://doi.org/10.1016/s0140-6736(20)32417-x

20. Kickbusch I, Liu A. Global health diplomacy—reconstructing power and governance. *Lancet 2022; 399(*10341), 2156–2166. https://doi.org/10.1016/S0140-6736(22)00583-9

21. Pang T, Guindon GE. Globalization and risks to health. *EMBO Reports*, 2004; 5(S1), S11–S16. https://doi.org/10.1038/sj.embor.7400226

22. Brown TM, Cueto M, Fee E. The World Health Organization and the transition from "international" to "global" public health. American Journal of Public Health 2006; 96(1): 62–72. https://doi.org/10.2105/AJPH.2004.050831

23. Frenk J, Moon S. Governance Challenges in Global Health. *New England Journal of Medicine*, 2013; 368(10): 936–942. https://doi.org/10.1056/NEJMra1109339

24. Smith R, Lee K. Global health governance: we need innovation not renovation. *BMJ global health*, 2017; 2(2): e000275. https://doi.org/10.1136/bmjgh-2016-000275

25. Kickbusch I. Global Health Governance Challenges 2016 - Are We Ready?. *International Journal of Health Policy and Management,* 2016; 5(6), 349–353. https://doi.org/10.15171/ijhpm.2016.27

26. Lee K, Piper J. The WHO and the COVID-19 Pandemic: Less Reform, More Innovation. *Global Governance* 2020; 26(4): 523–533. https://doi.org/10.1163/19426720-02604005

27. Evans T, Lee K. *Protecting our Collective Future: Renewing Canada's Role in Global Health*. Report of the Joint Expert Panel, Royal Society of Canada and Canadian Academy of Health Sciences, 2025. https://rsc-src.ca/sites/default/files/Global%20Health_EN.pdf

28. Gehring T, Faude B. A theory of emerging order within institutional complexes: how competition among regulatory international institutions leads to institutional adaptation and divisions of labour. *Review of International Organization* 2014; 9:471–98. http://doi:10.1007/s11558-014-9197-1

29. Kelly K. 100th birthday of IBM. *New York Times*, July 2011.

30. OECD. Government Innovation. OECD Policy Issue, n.d. https://www.oecd.org/en/topics/policy-issues/government-innovation.html

31. OECD. *Governments should strengthen public trust by improving efficiency, citizen engagement and access to public services*. OECD Press Release, Paris, 19 June 2025. https://www.oecd.org/en/about/news/press-releases/2025/06/governments-should-strengthen-public-trust-by-improving-efficiency-citizen-engagement-and-access-to-public-services.html

32. Hagel J, Seely Brown J, Davison L. The case for institutional innovation. *Harvard Business Review*, 4 March 2009. https://hbr.org/2009/03/the-case-for-institutional-inn

33. Joubert S. *3 Types of Innovation Changing the Future of Business*. Northeastern University Graduate Programs, 7 August 2024. https://graduate.northeastern.edu/knowledge-hub/types-of-innovation/

34. For example, see Lee K, Pang T. WHO: Retirement or reinvention? *Public Health* 2014; 128(2), 119–123; Lee K. Business as Usual: A Lack of Institutional Innovation in Global Health Governance. *International Journal of Health Policy and Management* 2016; 6(3): 165–168; and Smith R, Lee K. Global health governance: We need innovation not renovation. **BMJ Global Health** 2017; 2(2): e000275.

35. Meier B, Sirleaf M. Global Health Landscape: The Proliferating Actors Influencing Global Health Governance. In *Global Health Law and Policy*. Oxford: Oxford University Press, 2023, pp. 65-90. https://doi.org/10.1093/law/9780197687710.003.0004

36. Ravelo J. *Inside WHO's reforms: Progress, failures, and unfinished business*. Devex, 10 April 2025. https://www.devex.com/news/inside-who-s-reforms-progress-failures-and-unfinished-business-109812

37. Hagel J. Blog: Defining the big shift. *Edge Perspective*s, 2 August 2009. https://edgeperspectives.typepad.com/edge_perspectives/2009/08/defining-the-big-shift.html

38. Caro-Gonzales A. Driving systemic and multi-level transformative governance. In *Transformative Governance for the Future*. Springer Briefs in Business. Springer, Cham. https://doi.org/10.1007/978-3-031-43132-6_5

39. Mazzucato M. Governing the economics of the common good: from correcting market failures to shaping collective goals. *Journal of Economic Policy Reform* 2024; 27(1): 1–24. https://doi.org/10.1080/17487870.2023.2280969

40. UNAIDS (n.d.) *Impact of US Funding Cuts on Global AIDS Response*. Fact Sheet. https://www.unaids.org/en/impact-US-funding-cuts

41. Jerving S. Gavi pledges fall short about $2.9B as US pulls out. *Devex*, 25 June 2025. https://www.devex.com/news/gavi-pledges-fall-short-about-2-9b-as-us-pulls-out-110345?access_key=&utm_source=nl_checkup&utm_medium=email&utm_term=article&utm_content=text&mkt_tok=Njg1LUtCTC03NjUAAAGcCtFYJT7q7dfMU7Cy7bm_MMQz0YvlHS9bpDWyrwThTLV9bP9W_kpO5R4jYuxIVFPYXZvUZxwHIa6rVJf4mVksyH-O1ZO7_xqDTyKZFcY64fBA4sA

42. Reeves A, Gourtsoyannis Y, Basu S, McCoy D, McKee M, Stuckler D. Financing universal health coverage--effects of alternative tax structures on public health systems: cross-national modelling in 89 low-income and middle-income countries. *Lancet* 2015; 386(9990): 274–280. https://doi.org/10.1016/S0140-6736(15)60574-8

43. Raffer K. The Tobin Tax: Reviving a discussion. *World Development* 1998; 26(3). https://doi.org/10.1016/S0305-750X(97)10057-2

44. The Robin Hood Tax (n.d.) https://www.robinhoodtax.org.uk/index.html

45. Kerr C. Airline ticket tax to fund programmes. *Lancet Infectious Diseases* 2006; 6(6): 329. https://doi.org/10.1016/S1473-3099(06)70484-4

46. OECD. Base erosion and profit shifting (BEPS). Paris, 2024. https://www.oecd.org/en/topics/base-erosion-and-profit-shifting-beps.html

47. Campbell C, Yunnan Y, Park A. Inside the Global Quest to Trace the Origins of COVID-19—and Predict Where It Will Go Next. *Time*, 23 July 2020. https://time.com/5870481/coronavirus-origins/

48. Szarzec K, Dombi Á, Matuszak P. State-owned enterprises and economic growth: Evidence from the post-Lehman period. *Economic Modelling* 2021; 99: 105490. https://doi.org/10.1016/j.econmod.2021.03.009

49. Australian Department of Finance. Government Business Enterprises. Canberra, 2025. Accessed August 1, 2025 at https://www.finance.gov.au/government/government-business-enterprises

50. OECD. OECD Guidelines on Corporate Governance of State-Owned Enterprises. Paris, 2024. https://www.oecd.org/en/publications/2024/06/oecd-guidelines-on-corporate-governance-of-state-owned-enterprises-2024_68fa05cd.html

51. Tacheva B, Brown G, Bell D, von Agris J. The devil's in the detail: an appraisal of the use of innovative financing mechanisms for pandemic prevention, preparedness and response. *Globalization and Health* 2025; 21(1), 13–31. https://doi.org/10.1186/s12992-025-01103-w

52. Bishen S. *Why we need innovation and new funding models in the face of falling global health spend*. Health and Healthcare Systems, World Economic Forum,19 May 2025. https://www.weforum.org/stories/2025/05/falling-global-health-spend-innovation-new-funding-models/

53. Storeng K, de Bengy Puyvallée A, Stein F. COVAX and the rise of the 'super public private partnership' for global health. *Global Public Health* 2023; 18(1): 1987502. https://doi.org/10.1080/17441692.2021.1987502

54. World Economic Forum. *How to make non-financial reporting your company's north star*. Forum Institutional, 12 January 2023. https://www.weforum.org/stories/2023/01/esg-business-strategy-north-star-davos23/

55. Global 50/50. What we do. https://global5050.org/

56. Global Health Corps. *Our Mission, Vision, & Values*. 2025. https://ghcorps.org/about/our-mission-vision-values/

57. WomenLiftHealth (2025). https://www.womenlifthealth.org/

58. HSG (2025). *Emerging Voices for Global Health (EV4GH)*. https://healthsystemsglobal.org/emerging-voices-for-global-health-ev4gh/

59. Ng NY, Ruger JP. Global Health Governance at a Crossroads. *Global Health Governance* 2011; 3(2): 1–37.

60. OECD. *OECD Survey on Drivers of Trust in Public Institutions – 2024 Results: Building Trust in a Complex Policy Environment*, Paris, 2024. https://doi.org/10.1787/9a20554b-en

61. Storeng KT., et al. COVAX and the rise of the 'super public private partnership' for global health. Global Public Health 2023; 18(1): 1-17. https://doi.org/10.1080/17441692.2021.1987502

62. Wenham C, Potluru A. Costing the intergovernmental negotiating body (INB) process. *PLOS Global Public Health*, 2024; 4(12), e0003978. https://doi.org/10.1371/journal.pgph.0003978

63. National Coordinating Centre for Public Engagement. *A quick guide to developing quality public engagement*. University of Bristol, 9 October 2023. *https://www.publicengagement.ac.uk/resources/guide/quick-guide-developing-high-quality-public-engagement*

64. *Edelman Trust Barometer Global Report*. Edelman Trust Institute, 2025. https://www.edelman.com/sites/g/files/aatuss191/files/2025-01/2025%20Edelman%20Trust%20Barometer%20Global%20Report_01.23.25.pdf

## About Wellcome

Wellcome supports science to solve the urgent health challenges facing everyone. We support discovery research into life, health and wellbeing, and we're taking on three worldwide health challenges: mental health, global heating and infectious diseases.

## About Kelley Lee

Kelley Lee is the Tier 1 Canada Research Chair in Global Health Governance and Professor of Global Public Health in the Faculty of Health Sciences at Simon Fraser University in Canada.

Julianne Piper, Project Manager, Research Fellow and PhD Candidate, and Miranda Nonis, Project Coordinator and Research Fellow, both at the Faculty of Health Sciences, Simon Fraser University in Canada contributed to this paper.