

**Proposing a Global  
Commons Coordinating  
Council (GCCC) and**

**A Set of Six Enablers for the  
Global Health Architecture**

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A Perspective from the  
Asia and Pacific 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.

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# Executive Summary

## **Global health reforms must be based on short-term pragmatism and long-term idealism**

There are three pragmatic truths for reforms to the global health architecture. Firstly, global health, climate change and global economic justice are deeply inter-dependent in a Triple Challenge, so global health must coordinate collective action with the other two sectors. Secondly, nation-states are still the most significant and legitimate actors in global health, so the new architecture must create conditions and incentives for countries to compete in a “race-to-the-top” while governing non-state actors with separate mechanisms. Thirdly, creating a brand-new global health institution with meaningful powers is less realistic in a nationalist world in the 2020s, so it is more realistic to create a Global Commons Coordinating Council (GCCC) to achieve the same effect.

## **The proposed GCCC is the first step to a global commons governance council, equal to the security council**

The GCCC proposed in this paper is NOT a new institution but is a coordinating mechanism for five existing institutions: the World Health Organization, the United Nations Framework Convention for Climate Change Secretariat, the World Bank, the International Monetary Fund and the International Association of Insurance Supervisors. For brevity, they are called the “Big Five”. The WHO is proposed as the prime mover for the GCCC.

The GCCC has three initial objectives: 1) act as secretariat for nascent global health arrangements like SDG3 GAP and the Lusaka Agenda; 2) coordinate tri-sector collective action for the Big Five; and 3) be the first step towards an endpoint of a Global Commons Governance Council equal in stature to the UN Security Council (UNSC).

The GCCC has three alternative endpoints. One, the GCCC can self-impose a “finite lifespan” of 5-10 years before being reconfigured. Two, the Big Five can merge into one entity with a “super-mandate”. Or three, some GCCC members (e.g., the IMF or WB) can self-impose a finite lifespan (e.g., 20 years or the year 2045), to be replaced by a new global entity with a fresh mandate and architecture to solve the Triple Challenge (e.g., a Bank for Humanity).

As the GCCC would not be a new entity, it does not need new legal instruments or approvals from nation-states to launch, increasing the chances and speed of its successful launch. The Big Five are likely to support the GCCC because the counter-factual scenarios (a new global entity or the status quo) are less politically desirable to them. The Big Five can start the GCCC by systematically sharing info, then programs, operations and funding en route to a potential merger. They can also appoint each other’s apex leaders as ex-officio to their Executive Committees.

## **There are six enablers for the global health architecture, which are independent but can amplify the GCCC**

The GCCC simply cannot be a “single magic solution” for the wicked problem of global health. Therefore, we also need a set of six separate and independent enablers for the new global health architecture, especially for funding and enforcement. The six enablers and the GCCC are synergistic but can be implemented independently.

Enabler #1 separates global health functions, to increase resilience and to check-and-balance large forces. Enabler #2 proposes sunset clauses for legal instruments and even organizations, to increase their future legitimacy and relevance. Enabler #3 proposes a National Triple Score as a common standard to benchmark country performance, with indirect financial incentives in enabler #4 to reward good country performance. Enabler #5 proposes a layered compliance program with a United for Health Resolution in the General Assembly. Enabler #6 proposes a Global Financial Compact to invest trillions into humanity’s future.

The Triple Challenge is humanity’s defining challenge in this century. The GCCC is a bold yet pragmatic proposal, given the realities of nation-state primacy and their behaviors. The GCCC is mutually amplified by the six enablers, and the GCCC can gradually grow in scale and ambition into a Global Commons Governance Council that protects the global commons and global public goods, equal in stature and powers to the UNSC.

# Introduction: There are three pragmatic truths for global health reforms

To reform the global health architecture, we must start with three pragmatic truths:

## **One: To truly address global health, we must also address climate change and global economic justice**

We know that the global health architecture needs reforms to be more effective, equitable and efficient, among other goals. But since 2020, global health discourse has mainly focused on pandemics, perhaps sidelining other equally important subjects like the social determinants of health, sustainable financing and workforce resilience. Such a tunnel vision also exists elsewhere. For example, climate change mainly focuses on carbon dioxide<sup>1</sup> and less on biodiversity loss or over-consumption, potentially reducing a complex issue to “just a single molecule”.

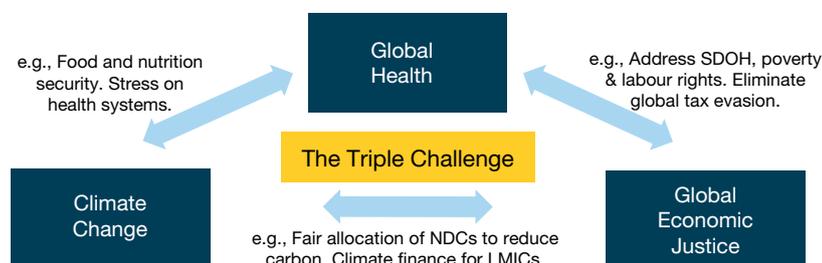
Framing global health with a narrow pandemic lens will limit the effectiveness, ambition, imagination and direction of reforms, and also perhaps reduces global health to pointless debates of “*My Issue X is more important than your Issue Y.*” Indeed, even a broader-than-pandemics Health in All Policies lens may not be broad enough for global health reforms to be truly effective. Using a much broader lens, we can see that Global Health intersects with Climate and Global Economic Justice in highly inter-dependent ways, and the three challenges cannot be solved in isolation. For brevity, we shall name these global challenges as the Triple Challenge.

The Triple Challenge affects the global commons.<sup>2</sup> They are also highly inter-dependent in three ways. One, the negative effects from one challenge worsens the other two. Two, progress in any challenge depends on progress in the other two. And three, the three challenges could compete for issue salience amidst limited global political & financial capital. Figure 1 shows concrete examples of the inter-dependencies in the Triple Challenge.

There is another advantage for health to work deeply with climate and economic justice in a Triple Challenge. Despite being such a huge USD 11.1 trillion sector (~10% of global GDP),<sup>3</sup> health is still considered “low politics”, compared to the “high politics” of security or finance.<sup>4</sup> Therefore, combining the political capital of health, climate and economic justice leaders is more likely to gain seats at the table to discuss reforms to Big Politics (i.e., power and regulations) and Big Finance (i.e., capital and fiscal policies) at both national and global levels.

In other words, reforming global health alone is not enough because 1) global health is much bigger than just pandemics, 2) global health intersects with climate and economic justice in a Triple Challenge, and 3) solving all three challenges may require simultaneous reforms to the entire global commons governance architecture.

**Fig 1:** Concrete examples of how the Triple Challenge is inter-dependent and inter-connected.



**Two: Global systems must still mainly govern nation-states, with one eye on non-state actors**

Like it or not, only nation-states have the political legitimacy to operate their national health and economic systems and the legitimacy and coercive power to raise revenue to fund their systems. This means that the main “unit of analysis” or “administrative unit” in any new global health architecture should still be the nation-state, although non-state actors like multinationals and private equity firms are becoming increasingly powerful.

However, Westphalian nation-states reliably act in Realpolitik terms, with vaccine apartheid during Covid being the prime example of self-interested nation-state behavior. Therefore, any new global architecture should create incentives for a healthy “race-to-the-top” competition between countries, enabled by an effective rewards and compliance program for countries (see enablers #3 and #4). That new architecture should also coordinate collective action (via the GCCC) and govern non-state actors with other mechanisms (see enabler #6), to incentivize non-state-actors to fulfill their duties to the global commons.

**Three: We need strong global institutions, but new institutions may no longer be realistic. Fortunately, we can coordinate existing institutions through a global commons coordinating council (GCCC).**

There are three fundamental constraints that effectively prevent the world from creating any new global health institutions (GHI) with meaningful powers. But we can design a GCCC to make these constraints work in our favor.

There are three fundamental constraints that prevent new GHIs... ... But we can design the GCCC to make the constraints work in our favor.	
A de-globalizing, nationalist and regionalist world lacks appetite and consensus for new global institutions or treaties with meaningful powers.	GCCC can coordinate existing global institutions without creating new institutions or consolidating existing institutions who are unlikely to give up power
GHIs (new or old) may compete with each other for issue salience, political capital and funding, sometimes with a dangerous “My crisis is more important than your crisis” approach.	GCCC can organize five members so they can speak “in one voice” with Presidents, Prime Ministers and Secretaries-General, while also maintaining their own individual communication channels.
Regional (e.g., ASEAN) or economic blocs (e.g., BRIC <sup>s</sup> ) are increasingly prominent, but they do not cover the world, do not have a systematic forum, and do not coordinate between themselves.	GCCC can gradually become a new forum for the Big Five to systematically work with new or old regional or economic blocs to coordinate collective action for the Triple Challenge.

# The global commons coordinating council (gccc) starts with three objectives and five members

The GCCC has three proposed objectives. One, the GCCC should act as a “secretariat” to systematically formalize the nascent arrangements between the Big Five, such as the SDG3 GAP (since 2019)<sup>5</sup> or the Lusaka Agenda (since 2023).<sup>6</sup> Two, the GCCC should coordinate collective action for the Big Five, allowing them to “speak in one voice” to the UN General Assembly (UNGA) and UN Security Council (UNSC). And three, the GCCC should be the first step of a multi-year journey to create a Global Commons Governance Council equal in stature and powers to the UNSC and complementing the UN Economic and Social Council (ECOSOC).

The Big Five are the WHO, UN FCCC, WB, IMF and IAIS. Other institutions can be future members. Regional blocs (e.g., ASEAN, Gulf Cooperation Council or MERCOSUR), politico-economic blocs (e.g., BRICS, G7 or G20) or trade blocs (e.g., RCEP) should be gradually added to the GCCC, along with other relevant organizations. As the GCCC progresses, non-traditional members can be added too, such as the International Organization of Securities Commissions that can help re-design financial regulations to unlock trillions for climate and health finance or the Institutional Limited Partners Association that has 600 members who are large pension or sovereign wealth funds that influence investment strategies. There should also be appropriate and non-tokenistic representation from traditionally under-represented groups like refugees, migrants, low-income countries and the young.

Health, Climate and Finance have a shared track record, but the inclusion of IAIS in the Big Five reflects the need to include Insurance as a new actor in global health, because insurance is large and shapes behavior. In 2023, insurers underwrote USD 7.2 trillion globally,<sup>7</sup> with individual, company and even sovereign policyholders<sup>8</sup> who want to reduce their risk exposure to reduce their insurance premiums. The role of insurance in global health reforms is described more in enabler #4.

This essay discusses the GCCC at the global, not national, level. The same effect can be achieved at country level with a “coordinating ministry” structure to organize national Cabinets, e.g., there can be a Coordinating Minister for Health, Climate and Labor. As a real-world example, Indonesia has seven Coordinating Ministers today.<sup>9</sup>

## Box: Addressing key questions on the triple challenge and GCCC

### Question 1: Does the triple challenge diminish other challenges?

No. Prioritizing health, climate and economic justice does not diminish peace, anti-genocide, rights or democracy efforts, which are crucial global public goods led by the UNGA and UNSC.

### Question 2: Does the GCCC compete with ECOSOC, UNGA or UNSC or other UN agencies?

No, and indeed, they can work together very well. Firstly, the GCCC does not compete with the ECOSOC for two reasons: one, ECOSOC is much broader to cover social, cultural and educational fields, while the GCCC only coordinates health, climate and economic justice. Two, the GCCC should be more action-oriented and systematically cover non-ECOSOC entities like private insurance, private capital and regional blocs. Secondly, the UNGA and UNSC do not generally lead health, climate or economic justice anyway. Thirdly, the UNGA, UNSC and ECOSOC may welcome GCCC speaking “in one voice” for the Triple Challenge, reducing negotiating costs. Fourthly, GCCC can have six-monthly GCCC Reports to the UNGA and annually to the UNSC, on top of more regular project meetings with ECOSOC and UN agencies.

### Question 3: Is it really difficult to build a brand-new global health institution (GHI) today?

Yes. The post-Cold War 1990s and 2000s embraced globalization and globalism, confident in liberal democracy and free-market capitalism as the “end of history” (see Fukuyama), gifting the world the Kyoto Protocol (1997), the Framework Convention on Tobacco Control (2005) and the Revised International Health Regulations (2007). But the world in the 2020s is different from the 1990s, with the withdrawal of the United States from global leadership, a sharpening global superpower and ideological rivalry, a tariff war and wars in Ukraine and Palestine. All these reduce the chances of a new GHI with meaningful powers being successfully agreed upon, funded and launched.

**Question 4: Even if feasible, are brand-new GHIs even desirable today?**

No, for three reasons. One, creating a brand-new GHI will consume years, funding and diplomatic energy, and still likely to end up with consensus decisions that dilute the original ambition. Such time, capital and energy should be deployed to act or coordinate action, not to convene a new GHI. Two, a brand-new GHI is undesirable because of fragmented and duplicated efforts; one study counted ~50,000 international NGOs today.<sup>10</sup> And three, a brand-new GHI assumes that current actors (notably nation-states) want another global actor when the evidence is showing that nationalism or regionalism is increasingly prominent. Therefore, a GCCC is a better alternative to coordinate action, including with regional blocs.

**Question 5: Why would the big five join the GCCC?**

Candidly, because the counter-factual scenarios are worse than the GCCC. The Big Five cannot judge GCCC in isolation but must weigh against two counter-factual scenarios: either an unrealistic brand-new GHI OR an ineffective status quo. Against both scenarios, the GCCC becomes politically acceptable for three reasons. One, the Big Five is not giving up or sharing power with a new entity. Two, the Big Five has the chance to increase their stature and effectiveness (assuming there is a critical mass of moral motive and not just selfish political considerations). Three, the GCCC can be positioned as a non-scary stepping-stone to much harder future reforms that require more political courage.

**The GCCC is bold, feasible and improves on other proposals**

The GCCC is bold yet feasible and politically acceptable. The GCCC also improves upon other proposals that create new GHIs. GCCC relative advantages are in green and relative disadvantages of other proposals are in red.

Names	<ol style="list-style-type: none"> <li>1. Global Preparedness Monitoring Board,<sup>11</sup></li> <li>2. Global Health Threats Council,<sup>12</sup> or</li> <li>3. Global Health Board<sup>13</sup></li> </ol>	The Global Commons Coordinating Council (GCCC)
Sponsor & Secretariat	<ol style="list-style-type: none"> <li>1. Sponsor: Uncertain.</li> <li>2. Secretariat: Uncertain</li> </ol>	<ol style="list-style-type: none"> <li>1. Sponsor: WHO proposed as prime mover.</li> <li>2. Secretariat: to be discussed by the Big Five.</li> </ol>
Legitimacy	<p>These are new institutions that need political and legal legitimacy with instruments needing approvals from nation-states at the World Health Assembly or UNGA</p>	<p>GCCC is not a new institution. It does not need new instruments, treaties or approval from nation-states, making GCCC politically acceptable and can be set-up quickly.</p>
Funding	<p>These are new institutions that need at least seed funds, if not operating funds</p>	<p>GCCC does not need seed funding, as it can be funded by the Big Five,</p>
Mandates	<ol style="list-style-type: none"> <li>1. Typically has a single-issue mandate, e.g., for pandemics or health security, which securitizes and limits the scope of health.</li> <li>2. These institutions do not interact with non-health actors in systematic ways.</li> </ol>	<ol style="list-style-type: none"> <li>1. Inside Health: the WHO can cover other health topics, not just pandemics.</li> <li>2. Outside Health: the GCCC has an ultra-wide mandate that includes Health, Climate, Finance &amp; Insurance.</li> </ol>

**The GCCC has a realistic roadmap: Start small, but be ultra-ambitious**

The prime mover for the GCCC should be the WHO, which can reach out to UNFCCC (a UN sister agency) as the second GCCC member. Getting either IMF or WB to join as the third member will likely encourage a domino effect for the fourth and fifth members. The WHO has a track record of and interest in convening non-health actors, such as the SGD3 GAP and Health Impact Investment Platform that partners multilateral development banks for primary care, demonstrating the WHO willingness and ability to convene non-health actors.<sup>14</sup>

**This table is an indicative roadmap for the GCCC. Progress may be faster with political will & positive results.**

Coordinate these Elements <sup>~</sup>	Years from Launch							
	2025	Y2	Y3	Y4	Y5	Y6	Y7	Y8
Political & Moral Capital	Dark Yellow	Light Yellow	Light Yellow	Light Yellow	Light Yellow	Light Yellow	Light Yellow	Light Yellow
Collect and Share Data	Dark Yellow	Dark Yellow	Dark Yellow	Dark Yellow	Dark Yellow	Dark Yellow	Dark Yellow	Dark Yellow
Joint Programs (incl Funding)	Grey	Dark Yellow						
Joint Routine Ops (incl Funding)	Dark Yellow	Dark Yellow	Dark Yellow	Dark Yellow	Dark Yellow	Dark Yellow	Dark Yellow	Dark Yellow
Merge Institutions?	Dark Yellow	Dark Yellow	Dark Yellow	Dark Yellow	Dark Yellow	Dark Yellow	Dark Yellow	Dark Yellow

Dark yellow indicates harder initial work. Light yellow is the steady state. Grey indicates discussion periods.

**By itself, GCCC is not a magic solution. It needs strong project management and execution.**

As a coordinating mechanism, the GCCC must have a regular cadence of operations. The GCCC can consider this sequence, although progress is not linear and can be simultaneous: The GCCC starts with the Big Five sharing political capital, e.g., standing invitations to Executive Committee meetings. This could grow into the Big Five sharing metrics and data, e.g., creating composite metrics for non-technical audiences to understand complex issues in a simpler way (see enabler #3), and then sharing programs, including funding and project management. Finally, the Big Five can merge routine operations or shared services while considering a formal merger.<sup>NEW</sup>

Separately, while senior leaders in the Big Five already have their personal networks built over decades, these networks can be strengthened and made more systematic. For example, apex leaders of the Big Five can be appointed as ex-officio, non-executive members of peer Executive Committees or Boards, e.g., the WHO Director-General joins the World Bank’s Board of Directors.<sup>NEW</sup>

**The GCCC can gradually become a governance council equal in stature to the security council.**

Depending on results, internal priorities and external events, after 5-8 years, the endpoint of the GCCC can be a Global Commons Governance Council equal in stature and powers to the UNSC. That Governance Council should manage the Triple Challenge, except peace, security and military interventions (managed by the UNSC) and socio-cultural goods (managed by ECOSOC).<sup>NEW</sup>

**There are three alternative endpoints for the GCCC**

Firstly, the GCCC can self-impose a “finite lifespan” of 5-10 years before being re-configured by the UNGA or similar entity. Secondly, the GCCC can build a founding rule that the Big Five must begin internal deliberations to merge, e.g., at Year 5 post-GCCC. And thirdly, it is not unfair to ask the Big Five (e.g., WB and IMF) to self-impose a 20-year deadline (i.e., 2045) to officially stop their operations and to be gradually replaced by a new and more inclusive global entity with a fresh mandate to solve the Triple Challenge, perhaps called a Bank for Humanity.

**Fig 2: A possible endpoint for the GCCC is a Governance Council equal to UNSC.**



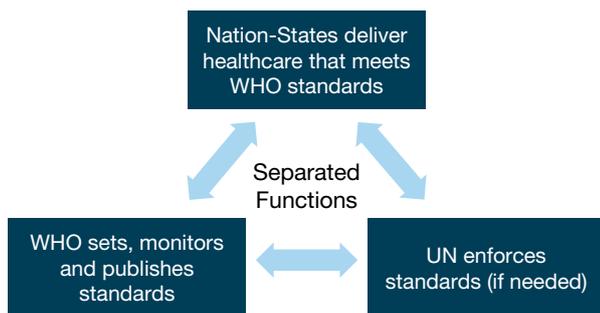
# There are six independent enablers for the new global health architecture

This essay proposes six enablers for the new global health architecture which are independent of but will mutually amplify the GCCC. The GCCC and the six enablers can be implemented independently.

## Enabler #1 Separate the functions: Separate functions to create checks-and-balances NOT NEW

Modern nation-states follow the Montesquieu doctrine of Separation of Powers<sup>15</sup>. This doctrine should also be applied to the new global health architecture:

Fig 3: Separated functions between major existing entities in global health.



The new global health architecture should not aim to have a monolithic “super-entity” that performs multiple functions, even if such an entity is politically and legally realistic. Any monolithic entity can become too-big-to-fail, too-big-to-manage, or even too-big-to-understand. Therefore, the four clearly different functions of setting, monitoring and enforcing standards, and delivering services should be separated between different entities.

Separated functions have many benefits because they: NEW

1. Increase system resilience because global health can be “too-big-to-manage”.
2. Maintain nation-state primacy while creating intrinsic checks-and-balances between large forces.
3. Conserve resources by using existing enforcement mechanisms (e.g., UNSC or International Court of Justice) with legitimacy, decades of track record, institutional memory and internal capabilities. NEW
4. Preserve WHO neutrality, because other UN agencies are enforcing standards (not the WHO). NEW

The WHO functions mandated by its Constitution are still necessary and desirable. However, there are some global health functions (specifically financing and enforcement) that are necessary but cannot be performed by WHO unless the WHO receives a mandate and funding from its Member States, the UNGA and donors. In other words, any suggestions that the WHO must fund and/or enforce global health are both impractical (because of politics) and undesirable (because of the need for separated functions).

Low-income countries, fragile or conflict states and humanitarian crises must still be supported by funding (by foreign aid, private philanthropy or development financial institutions) or service delivery (by NGOs or foreign aid), while building durable solutions for peace, economic growth and self-reliance. Enabler #6 describe more funding options. GHIs like GAVI and The Global Fund should gradually reduce their direct service delivery and transfer responsibilities to nation-states (but not reduce GHI service delivery to zero, to account for fragile states), while transitioning to a more global public goods or catalytic function, or even to sunset themselves.

## Enabler #2 use sunset clauses: Legal instruments and even organizations should auto-expire NEW

A “sunset clause” is a clause that states that that law automatically expires on a certain date, unless re-approved (in other words, an auto-expiry). Sunset clauses or fixed review periods are included in the Constitution of India and several laws in Australia, Canada, the United Kingdom and the United States.<sup>16</sup> In global health, instruments with sunset clauses have several benefits: NEW

1. Renewed instruments acquire new legitimacy when they are extended by new decision-makers.
2. Renewed instruments help global health become more flexible and adaptable, lowering the risk of “old instruments that do not meet new realities”.
3. Renewed instruments promote inter-generational equity when younger people who come-of-age later decide if they want (or do not want) to bear the obligations of the old instruments.

Indeed, even organizations can sunset themselves. Two examples from 2025 alone are the Gates Foundation announcing they will close on 31 Dec 2045 and GAVI announcing “finite lifespans” as a principle.<sup>17</sup> Such finite lifespans create a “burning platform urgency”, reducing psychological dependence and increasing moral legitimacy

for the institutions. It is beyond this essay to describe the specific criteria and implementation of sunseting, but there are two useful guiding principles: to gradually introduce sunseting over 5-10 years (e.g., built-in sunsets for policies, then programs, then entire organizations) and to internally debate what parts of an organization “must be timeless and unamendable” versus “should be time-limited and sunset-able”.

**Enabler #3 build a national triple score (NTS): A common standard to benchmark countries** <sup>NEW</sup>

The NTS is a composite score of a country’s performance, with three components of Health, Climate and (later) Economic Justice metrics. The NTS should be a common standard to benchmark countries, to reward countries with good performance (see enabler #4). For the Health component, the WHO can convene an expert panel and use Modified Delphi to select the right set of summary measures of population health and system performance.<sup>18</sup>

The right metrics are meaningful, politically acceptable and within the direct control of countries.

There are several caveats to the NTS rankings and methodology. No single “set of metrics for NTS” will be perfect. There should be a mix of leading and lagging indicators. The set of metrics can itself have a sunset clause. NTS metrics and rankings can be stratified by World Bank country income levels. Although the quality of data collection will always be imperfect and statistics can always be politicized, the solution is to improve transparency and data standards, not to abandon statistics or the concept of the NTS rankings.

Once the NTS methodology is confirmed, the WHO should monitor and publish results using tools that reflect the complexity of health, e.g. bubble charts instead of bar charts. NTS rankings rank countries relative to their peers. Countries with higher NTS rankings can enjoy lower interest rates (an example described in enabler #4).

**This table shows an example set of metrics for the NTS Health component, based on the healthcare triple aim.<sup>19</sup> The data is currently already collected by WHO and other partners, to prevent duplicate efforts.**

Health Professionals	Access	Cost	Quality
<ol style="list-style-type: none"> <li>1. Number of doctors, nurses and midwives per 1000 population.</li> <li>2. % of doctors, nurses &amp; midwives foreign-trained or -born.</li> </ol>	<ol style="list-style-type: none"> <li>1. Universal Health Coverage Service Coverage Index.</li> <li>2. % of births attended by skilled health personnel.</li> </ol>	<ol style="list-style-type: none"> <li>1. Domestic govt health expenditure as % of govt expenditure and current per capita health expenditure (PPP).</li> <li>2. SDG 3.8.2 Catastrophic Health Spending (and related).</li> </ol>	<ol style="list-style-type: none"> <li>1. IHR Self-Assessment Annual Report.</li> <li>2. Age-standardized Mortality Rate (“MR”) + Infant MR + Maternal MR.</li> </ol>

**Enabler #4 Build a Rewards Program: Use NTS rankings to reward good performance** <sup>NEW</sup>

The GCCC, supported by the UN and INGOs, can formally request financial institutions (or FIs) to include the NTS rankings as one additional criterion in their business decisions. This creates a network and critical mass of powerful indirect financial incentives, which be powerful drivers to encourage countries (and even politicians) to improve their performance in NTS rankings and compete in a “race-to-the-top”.

FIs are likely to provide indirect financial incentives based on the NTS common standard, because: <sup>NEW</sup>

1. NTS rankings reward countries and do not penalize countries.
  - a. Countries should be rewarded for high NTS rankings, not punished for low NTS rankings.
  - b. Therefore, countries with low NTS rankings get the “default treatment” (not “worse treatment”), and countries with high NTS rankings get “better treatment”.

2. As a concept, NTS rankings are likely to be acceptable and even desirable to FIs:
  - a. NTS rankings are “one additional criterion”, and are not the sole, main or first criterion.
  - b. NTS rankings do not replace any existing criteria in the routine operations of FIs.
  - c. FIs have sole discretion to assign the relative weightage for NTS rankings (versus other criteria).
3. FIs are incentivized to offer indirect financial incentives to countries because of:
  - a. Self-interest: FI business decisions become more accurate and complete with the NTS.
  - b. Legitimacy: FI shareholders, stakeholders and clients are likely to support the concept.
  - c. No cost: There is almost zero financial or political cost to FIs to offer the financial incentives.
4. Although it is empirically difficult to disentangle, there is evidence that better population health leads to higher economic growth<sup>20</sup> and a better ability to repay loans or a lower risk on sovereign bonds. Therefore, FIs are likely to welcome a reliable tool to help assess risk more accurately.
5. Additionally, GCCC and the UN can also recognize participating FIs, via the UN Global Compact, a certification like the Rainforest Alliance certification, or other appropriate recognition.

**Box: Examples of the ways that different FIs could use the NTS rankings as one additional criterion in their routine business decisions.**

**IMF, WB and DFIs (e.g., ADB, AIIB):** When determining interest rates for loans. For example, the IMF can include NTS rankings as one additional criterion when determining interest rates for Special Drawing Rights.<sup>NEW</sup>

**Re-insurers and insurers:** When assessing insurance and re-insurance risk for countries. NEW IAIS can also build new actuarial models to price in the negative externalities (e.g., public health risk and climate risk) and create underwriting guidelines for social health and climate insurance products.<sup>NEW</sup>

**Credit Ratings Agencies:** When assessing the credit rating for countries or credit ratings for countries’ sovereign bonds, treasuries or debt.<sup>NEW</sup>

**Limited partners of asset management and private equity firms, including sovereign wealth funds:** When assessing macro-environment and investment risk. Limited partners and sovereign wealth funds take a more long-term view than asset management/private equity firms and may be more receptive to overtures from the health sector.<sup>NEW</sup>

**Business indices:** Include NTS rankings as one additional criterion in indices that matter to countries for prestige or investment reasons, such as the Ease of Doing Business index (World Bank), B-READY Report (World Bank), the Global Competitiveness Report (World Economic Forum), the World Competitiveness Ranking (IMD) and ESG Frameworks (e.g., ISO 14001, or GRI).

We must acknowledge the backlash against the Washington Consensus in the 1990s-2000s.<sup>21</sup> Fortunately, there is lower risk of a backlash against NTS rankings. This is because the Consensus was 1) primarily used in sovereign debt crisis situations or as a pre-condition to loans and 2) are arguably ideological and subjective, but the NTS rankings are not used in crises, are not a pre-condition to loans and are arguably more common and objective.

## Enabler #5 build a parallel compliance program: Verify and enforce global health commitments <sup>NEW</sup>

A meta-analysis of 250,000 international treaties between nation-states (including UN treaties) shows that most do not “produce their intended effects” and that enforcement is essential for success.<sup>22</sup> At the same time, to achieve such compliance with international commitments, “there is unlikely to be a ‘single best accountability mechanism’<sup>23</sup>. Therefore, to signal seriousness and to occasionally compel nation-states to meet their global health obligations, we need a set of tools parallel to the parallel to the indirect financial incentives described in enabler #4.<sup>NEW</sup>

### Verification measures: “trust but verify”

Instruments like the NTS rankings, the IHR Joint External Evaluation (JEE), the FCTC or the Pandemic Agreement can benefit from a three-review approach for verification, in a layered-risk-reduction philosophy. This table shows the three types of reviews, and examples of their real-world use in global governance across a range of sectors:

Self-Reviews	Peer Reviews	External Reviews
1. Human Rights Council, Universal Periodic Review process	1. World Trade Organization, Trade Policy Review Mechanism	1. Paris Agreement, Nationally Determined Contributions
2. Tripartite Antimicrobial Resistance country self-assessment survey	2. Financial Action Task Force, Mutual Evaluation	2. International Labor Organization, Committee of Experts

Reviews can sometimes be contentious, so the methodology and results of these reviews should always be fully transparent. Lessons should be drawn from the deep experience of the Permanent Court of Arbitration, the International Court of Arbitration and the World Trade Organization Dispute Settlements unit.

### Hard enforcement: proposing a “uniting for health” resolution in the UNGA <sup>NEW</sup>

This author proposes sanctions as the last-resort option for serious acts of non-compliance that clearly threaten global health security, as decided by the UNGA & UNSC through regular procedures. There should be no “first-resort use of sanctions” and the WHO should never decide. But are sanctions in global health even legal?

Firstly, such hard enforcement is not unthinkable, even today. One, the Universal Declaration of Human Rights and the WHO Constitution link health to human rights and to “the attainment of peace and security”.<sup>24</sup> Two, the UN Charter empowers the UNGA and UNSC to protect human rights and international peace and security. In other words, there may already be some legal basis for the use of sanctions in global health, even today.

Secondly, the UNSC veto can be (ab)used to prevent sanctions (it is beyond this essay to propose abolishing the veto). But there is a workaround: UNGA Resolution 377A(V) from 1950 called Uniting for Peace (U4P). If the UNSC has “lack of unanimity” (i.e., a veto is used), U4P allows “making appropriate recommendations ... for collective measures to maintain or restore international peace and security” by the UNGA.<sup>25</sup> The U4P Resolution has been used at least 12 times, most recently in 2022 for Ukraine.<sup>26</sup> In other words, U4P can “circumvent” the veto.

Therefore, we can contemplate a Uniting for Health (U4H) Resolution in the UNGA, with the same intention and mechanism as U4P. The U4H Resolution can be the final piece of the global health compliance program, laying the legal legitimacy for sanctions for serious acts of non-compliance that threaten global health (or climate security). The U4H does not even need be used; its mere existence is already a strong signal of enforcement intent.

## Enabler #6 rebuild financing: address financialization & build predictable health financing <sup>NEW</sup>

The global health architecture should first be correctly designed so that funds can flow in effective, efficient and equitable ways, without fraud, waste and abuse. Then, we can manage the financialization of the global economy, evidenced by a staggering USD 469 trillion of financial assets in 2020, 5.4X global GDP.<sup>27</sup> An over-financialized economy has negative effects on the world and on the Triple Challenge.<sup>28,29</sup> One, it increases economic inequality, which reduces tax revenue and reduces employment-linked healthcare coverage. Two, it reduces investments in the real economy, which reduces innovation, good jobs and tax revenue. And three, there is a risk of capital flight and debt-driven growth, which reduces resilience of societies, economies, health systems and welfare systems.

**Therefore, there should be a new “global financial compact” or social contract <sup>NEW</sup>**

The prime movers should be the UN, GCCC, the FSB, BIS, sovereign wealth funds and other major Fis. The Compact should aim to a) reconfigure global finance to invest trillions in humanity’s future, b) rewrite regulations and incentives to

shift global finance from narrow short-term goals to broad long-term ones, c) redesign institutions to allocate finance to health-promoting investments on a global scale, and maybe d) design reasonable constraints on mega-non-state financial actors. In this Compact, the purpose of capital should be human development, not profit.

From the philosophical, moral and legal foundation provided by the Compact, we can build more predictable and sustainable financing for health. This table shows specific proposals (bold suggestions are in red):.

Proposals	Details
Global Digital Tax <sup>NEW</sup>	A 0.5% tax on all declared worldwide profits of Big Tech and Social Media companies, payable to the United Nations, on a voluntary basis in the first five years. <sup>30</sup>
AMCs <sup>NOT NEW</sup>	ACT-Accelerator and COVAX benefited from Advance Market Commitments (AMCs). The GCCC can use the AMC concept to incentivize research & development.
Fixed Formulas <sup>NEW</sup>	Fixed formulas help Health Ministries and Treasuries to plan ahead, do not shock the “absorptive capacity” of Health Ministries, and reduces annual negotiations. For example: <b>1. Governments can “lock-in” a fixed formula, e.g., 5% annual increase in the health budget for the next five years, with a sunset clause requiring re-approval in Year 5.</b> <b>-2. Governments can commit to “X% of GDP on health”, like the NATO “2% of GDP on defense”.</b>
Diversify Sources of Funds <sup>NOT NEW/NEW</sup>	This could include: 1. Issuing health bonds: structured as revenue bonds +/- outcome-based payments. 2. Catalytic, impact or co-financing: government matches private capital 1:1. <b>3. Shariah tools: there are ~2 billion Muslims globally. Shariah-compliant tools like <i>Takaful</i> insurance (~USD 112 billion in 2034<sup>31</sup>), <i>Zakat</i> alms (~USD 21 billion annually in Indonesia alone), <i>Waqf</i> endowments and <i>Sukuk</i> bonds can help diversify health funding.</b>
Use Funds Well <sup>NOT NEW</sup>	<b>We will never have “enough money for healthcare”. Therefore, we must spend well and Ruthlessly Eliminate fraud, waste, abuse, corruption &amp; middlemen.</b> Other tools should include: strategic purchasing; value-based healthcare; diagnosis-related groups; price transparency; and reform of provider payments., including at the global and regional procurement levels.

**There is a realistic and fiscally responsible way for Asia to meet a global health funding gap <sup>NEW</sup>**

There is a ~USD 16.6 billion annual funding gap in global health due to changed United States foreign policies in 2025 (~USD16 billion for USAID and ~USD 600 million for the WHO). To meet this gap, 11 high-income and upper-middle-income Asian countries<sup>32</sup> can gradually commit 0.5% of their national budgets annually for health-oriented foreign aid. That can already mobilize ~USD 30 billion annually to global health, either as direct aid, interest-free loans, impact investment, catalytic bonds or innovative financial instruments other than traditional aid.

The 11 countries should gradually increase allocations, e.g., start with 0.1% of national budgets annually in Years 1-3,

then 0.3% in Years 4-6, and then 0.5% annually in Year 7 onwards. The allocations should be managed by their aid agencies (e.g., CIDCA, JICA or KOICA) or a committee of their Health and Foreign Affairs Ministries. Funds should be disbursed in unconditional and non-ideological ways, focused on strengthening health systems in recipient countries. Their Cabinets, Parliaments or Auditors-General should provide oversight and governance with full transparency and anti-corruption measures. The 11 Asian countries are likely to view this idea favorably because 1) they see an opportunity to shape an emerging multi-polar world, 2) they are trading nations that want to help “prosper-thy-neighbors”, 3) they decide how the funds are disbursed, and 4) they increase their soft power.

# Closing: “create the conditions for many others to act”

We must humbly acknowledge that the task “to design a global architecture” may be paternalist, even if the architecture itself is necessary. **Can a few smart people in a room really design an architecture for a world too-big-to-understand?** This world has ~8 billion people, ~200 countries, ~250,000 treaties, ~50,000 international NGOs and ~10 million local NGOs,<sup>33</sup> ~104 million private companies and 48,000 listed companies with a combined valuation of USD 125 trillion,<sup>34</sup> USD 469 trillion of financial assets, USD 11.1 trillion annual health spending<sup>3</sup> and 41.6 billion tons of CO2 emitted in 2024.<sup>35</sup> If this is too-big-to-understand, it is also too-big-to-manage.

Therefore, the main role of any new global health architecture or new actor may not be “to act”, but “**to create the conditions for many others to act, to coordinate collective action and to build checks-and-balances for large forces**”. This role is humbling, effective and provides agency and dignity to billions of actors, all necessary for *Homo sapiens* to survive this century. That role is best filled by the GCCC, as a bold yet pragmatic starting point for a multi-year journey to a Global Commons Governance Council equal in stature and powers to the UNSC.

# Acknowledgements

Dr Abu Bakar Suleiman (former Director-General of Health, Malaysia), Dr Cheng-Chwee Kuik (National University of Malaysia, IR expert), Dr David Bishai (Hong Kong University), Elina Noor (Carnegie Endowment for International Peace, IR expert), Dr Peter Singer (former Special Adviser to the WHO Director-General), Dr Sabina Faiz Rashid (BRAC University, Bangladesh) and colleagues from Angsana Health provided valuable comments. This author is fully responsible for this essay, including all analyses, opinions and errors. All hyperlinks valid on 31 July 2025.

## Acronyms

AM: Asset Management	INGO: international non-governmental organization
AMC: Advance Market Commitment	IR: International Relations, as an academic discipline
BEPS: Base Erosion and Profit Shifting	NTS: National Triple Score
ECOSOC: UN Economic and Social Council	PE: Private Equity
ESG: Environmental, Social and Governance	SDG: Sustainable Development Goals
FI: Financial Institutions	SDG GAP: SDG Global Action Plan
FCCC: Framework Convention on Climate Change	SWIFT: Society for Worldwide Interbank Financial Telecoms
FCTC: Framework Convention on Tobacco Control	UN: United Nations
GCCC: Global Commons Coordinating Council	UNDP: UN Development Program
GDP: Gross Domestic Product	UNGA: UN General Assembly
IHR: International Health Regulations	UNSC: UN Security Council
ILPA: International Limited Partners Association	WHO: World Health Organization

## Regional Blocs

ASEAN: Association of Southeast Asian Nations, an association of ten nations in Southeast Asia	MERCOSUR: Mercado <i>Común del Sur</i> . Southern Common Market in English. A trade bloc for South America
BRICS: acronym of Brazil, Russia, India, China and South Africa	NATO: North Atlantic Treaty Organization
G20: Group of Twenty	RCEP: Regional Comprehensive Economic Partnership, a multi-country trade agreement.
G7: Group of Seven	

## Global Health Institutions (GHI), Aid Agencies or Multilateral Agencies

ADB: Asian Development Bank	KOICA: Korea International Cooperation Agency
AIIB: Asian Infrastructure Investment Bank	WB: World Bank
CIDCA: China International Development Cooperation Agency	IMF: International Monetary Fund
DFI: development financial institutions (e.g., the ADB and AIIB)	BIS: Bank of International Settlements
GHI: global health institution (e.g., The Global Fund or GAVI)	FSB: Financial Stability Board
JICA: Japan International Cooperation Agency	OECD: Organization of Economic Cooperation & Development

# Endnotes

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## About Wellcome

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