

Latin America and the Caribbean **Dialogue on Reforming the Global Health Architecture**

Dialogue Outcomes
Document

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Foreword

Working in global health over the past 40 years, I have come to see that the task of discussing how to reform the global health system is profoundly challenging. To start, we need to recognize that “the system” exists only as a metaphor. It is not a concrete system like the system that runs my watch or the system that runs my old car; these things can be physically touched and concretely defined. The global health system, by contrast, is more intangible and ambiguous. Its boundaries and borders are poorly defined and hotly contested. Who decides what is inside the system and what is outside? Who assigns roles among the actors or elements of the system? Yet, even without clear boundaries, there is broad agreement that the global health system is changing.

Many people talk about the “architecture” of the global health system. But we need to recognize that there is no “architect” systematically designing and thinking about how to redesign it. We have a global health community made up of neighborhoods where each owner decides the structure, the land, and the design of its buildings, in competition with neighbors, depending on their relative power. Global health is a patchwork quilt with gaps and overlaps, with each piece created through crises and opportunities at critical historical moments. The result today is a quasi-system that has achieved successes but would benefit from a critical review to achieve better performance in the 21st century.

In my view, the goal of this dialogue is not consensus but rather the search for good and innovative ideas. Tractable changes that hold the potential for making positive differences. This may require disruption of the existing order; it may require confronting uncomfortable patterns. But I am confident that this exercise is worth doing, if it can provoke thoughtful action. In the pages that follow, look for inspiration and guidance on rethinking the challenges that the global health community confronts today, with hints from Latin America and the Caribbean. I hope that the document will contribute to this needed rethinking, so that we can be more effective in achieving the ethical principles of global health for a better world.

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Abbreviations

BCIE	Central American Bank for Economic Integration
CAF	Development Bank of Latin America and the Caribbean
CARICOM	Caribbean Community
CDC	Center for Disease Control
CELAC	Community of Latin American and Caribbean States
COP30	World Climate Summit (2025 United Nations Climate Change Conference)
D4D	debt for development
HTA	health technology assessment
IDB	Inter-American Development Bank
IECS	Institute for Clinical Effectiveness and Health Policy
LAC	Latin America and the Caribbean
LAC-HCP	LAC Health Catalytic Platform
M&E	monitoring and evaluation
ORAS-CONHU	Andean Health Organization – Hipólito Unanue Agreement
PAHO	Pan American Health Organization
PHC	primary health care
RPG	regional public goods
SICA	Central American Integration System
SIDS	Small Island Developing States
UHC	universal health coverage
UWI	University of the West Indies
WHO	World Health Organization

Executive Summary

This document synthesizes a regional dialogue that engaged stakeholders from the 33 countries of Latin America and the Caribbean (LAC) to reimagine the global health architecture. The consultation—comprising 75 in-depth interviews, an open survey, three subregional webinars, and a high-level convening in Mexico City gathering 44 regional actors—reflects diverse voices from government, academia, civil society, regional institutions, the private sector, and multilateral organizations.

Where we are now: LAC occupies an ambiguous position within the current global health architecture—*“neither poor enough to receive substantial cooperation, nor rich enough to sit at the decision-making table.”* The region experiences a system designed by and for the Global North, with financing and priorities focused on vertical programs that do not align with LAC’s predominant challenges: noncommunicable diseases, mental health, climate vulnerability, and health system strengthening. Large multilateral bodies are perceived as bureaucratic and insufficiently responsive, while fragmented coordination creates duplication and administrative overload. However, critical regional assets exist: the Pan American Health Organization Revolving Funds demonstrate proven market-shaping capacity, technical cooperation remains strong, and there is significant untapped potential for South-South collaboration and regional public goods production.

Reimagining the future architecture: Reform must be regionally grounded and globally connected. The proposed architecture involves refocusing global mandates on stewardship, norm-setting, and emergency coordination, while devolving technical cooperation to strengthened regional mechanisms. Governance must become more inclusive, transparent, and binding. Three interconnected platforms would operationalize this vision: (1) a LAC Innovation Hub to systematize peer-to-peer technical exchange; (2) a LAC Health Catalytic Platform to coordinate investment in regional public goods and enable joint procurement and manufacturing; and (3) a Regional Solidarity Fund to pool catalytic financing from multilateral banks, innovative taxation, and domestic resources.

How to enable this new architecture: Implementation requires securing high-level political and financial leadership. LAC heads of government, ministers of finance, and regional champions must drive the agenda through regional summits and global forums. This political platform must be anchored in binding agreements sustained beyond electoral cycles. In parallel, the region should modernize existing mechanisms, establish innovative domestic revenue sources, and integrate health into broader economic, climate, and trade strategies through “Health in All Policies” frameworks engaging the non-health ministries that control necessary political and financial levers.

LAC brings a tradition of solidarity, proven pooled procurement models, and deep experience managing diverse contexts. By strengthening regional self-sufficiency and amplifying LAC’s voice globally, this reform agenda can transform the region’s health future while contributing to a more equitable and responsive global health architecture for all.

Purpose of the Document

This dialogue outcomes document synthesizes the perspectives, priorities, and reform proposals collected through an inclusive consultation process that engaged more than one hundred actors across all countries of the LAC region between August and November 2025. It reflects the insights of government representatives, regional institutions, academia, civil society, the private sector, and technical experts, ensuring a diverse and regionally grounded assessment of how the global health architecture can be transformed. The document does not claim to represent a unified regional position but rather captures the breadth of experiences and ideas that emerged through this wide-ranging dialogue.

Background

The LAC Dialogue on Reforming the Global Health Architecture—alongside four parallel dialogues in Asia and the Pacific, Africa, Europe and North America, and the Middle East and Central Asia—is part of a Wellcome Trust initiative to leverage collective thinking and surface emerging areas of consensus on global health reform priorities, drawing on ideas set out in initial proposals commissioned from innovative thought leaders and on those that emerge through the dialogues. The dialogue in the LAC region was led by an academic consortium formed by Tecnológico de Monterrey (Mexico), Universidad Mayor (Chile), the Institute for Clinical and Health Effectiveness (IECS, Argentina), and the University of the West Indies (UWI, Jamaica). Teams from all four institutions brought together different areas of expertise to form a shared view and better understand stakeholders’ perspectives on the current global health architecture.

A central point of debate concerned the region’s place and role in global health. Participants reflected that LAC has shaped major global health agendas in recent decades—championing universal health coverage (UHC), advancing primary health care (PHC), and pushing back against harmful commercial determinants of health. However, the LAC region’s participation in the global health architecture has largely been marginal, resulting in minimal influence over priorities, financing decisions, and the design of global mechanisms. Furthermore, the LAC region is often treated as a unified region, yet it is characterized by significant cultural, geographic, demographic, and socioeconomic diversity that produces equally diverse health needs and system capacities. For instance, subregions such as the Caribbean and South America differ markedly in scale, resources, and institutional structures; countries range from small island states with acute climate and structural vulnerabilities to large middle-income economies facing fiscal pressures, political instability, and fragmented health systems. Although most LAC countries are classified as middle- or upper-middle-income, persistent inequalities, high out-of-pocket expenditures, and widespread unmet health needs mean that millions of people continue to live in poverty with unmet health needs.

This dialogue represented a unique opportunity to debate, contrast, and build reform proposals from the region’s diversity, identifying points of convergence that can form a joint voice in the global debate that will take place in 2026.

Box 1. Methodology

Stage 1: Regional consultation:

- One-on-one interviews with 75 key actors: Interviewees were identified through comprehensive stakeholder mapping supported by AI-assisted web scraping to ensure balance across sectors. Interviews centered on three questions: (1) Where are we now? (2) What should be the function and form of the future global health architecture? (3) How can this new global health architecture be enabled?
- A public online survey consisted of a series of questions aimed at capturing views on global health system priorities, challenges, and opportunities for reform. The survey collected more than 40 responses.
- Three subregional webinars with more than 100 participants overall where preliminary findings from the interviews were shared and discussed.

We implemented a two-stage, time-bound, multi-stakeholder consultation that included the perspective of 75 interviewees and 44 participants in the convening from the 33 countries of the region and engaged different sectors, such as government, academia, private-sector organizations, multilateral agencies, and civil society groups across most of the countries in the region.

Stage 2: Regional convening:

An in-person meeting in Mexico City (12–13 November) brought together 44 regional stakeholders to examine five priority themes: (1) Keeping and strengthening what works; (2) Ensuring sustainable financing; (3) Reforming major global health institutions and exploring innovative governance arrangements; (4) Redesigning the global health architecture to achieve health equity; and (5) Strengthening technical cooperation and coordination among countries.

Taking Stock

Key challenges of the current global health system

The region's needs are not reflected in the current top-down system

- There is a shared sense in LAC of being at the margins of a global health system that remains largely conceived, governed, and financed from the Global North, as well as limited due to criteria used for assignment of resources: *“neither poor enough to receive large flows of cooperation, nor rich enough to finance its own solutions [...] We are neither recipients nor donors [...] we are taken out of the game.”* This results in the loss of non-reimbursable aid and favorable financial conditions.
- Global cooperation and financing continue to prioritize other regions and vertical issues such as malaria and HIV. While these approaches have yielded important gains for vulnerable populations, they also narrow the scope of support, diverting attention from the region's predominant health challenges—noncommunicable diseases, primary care, mental health, and the broader need for comprehensive health-system strengthening.

A complex and fragmented architecture deters effective technical collaboration

- Large multilateral bodies are perceived as bureaucratic, slow to adapt, and structured in ways that limit technical responsiveness and innovation, often resulting in collaboration that remains largely administrative rather than leading to concrete actions: *“Ninety percent of what we do is PowerPoint. Very little reaches the field, very few real solutions.”*
- The current architecture does not promote synergies among global, regional, and national levels. Instead of complementing existing capacities, many international actors operate in parallel, creating duplication and displacing functions that could be more effectively carried out by local or regional institutions. Moreover, relying on external actors often results in tools and analyses that are not tailored to local needs: *“We need to start by mapping the capabilities we have in each country and what each can offer. And part of the process is helping countries improve their capabilities.”*
- Deep fragmentation and a crowded field of actors with diverse and duplicate agendas undercut cross-learning and cross-fertilization. Aspects include short-term funding cycles, weak and outdated coordination mechanisms, and entrenched power asymmetries that constrain country ownership, sufficiency, and strategic coherence—while overloading the administrative capacity of the recipient countries: *“Coordination is deficient, and organizations compete against each other”; “...everything is a priority, and we’re all pulling in all directions.”*

Regional heterogeneity and contexts require consideration

- **Overlooked vulnerabilities:** Small Island Developing States (SIDS) are classified as “high-income” despite having to invest significant resources annually to recover from climate emergencies and natural disasters.
- **Nonexistent South-South financing:** A major challenge lies in financing international and South-South cooperation, as no sustainable mechanisms currently exist for regional cooperation.

Keeping and strengthening what works

Participants expressed optimism about working together regionally despite acknowledging *“language barriers and lack of a strong regional identity.”* This optimism rests on recognition of shared challenges—inequality, fragmented systems, exclusion from global decision-making, and climate vulnerability—that transcend subregional differences. As one participant noted, *“There was a feeling of common identity as a region... regardless of diversity and differences among subregions.”*

Production of global public goods: The Pan American Health Organization (PAHO), the World Health Organization (WHO), and multilateral development banks generate technical standards, regulatory guidance, scientific evidence, and reports and statistics that countries rely on for decision-making. There is strong interest across the region in strengthening its ability to produce its own regional public goods, ranging from knowledge generation to surveillance and monitoring. Expanding regional capabilities would make the system more responsive and grounded in real conditions.

Proven market-shaping capacity: PAHO’s Revolving Funds have demonstrated the region’s ability to shape health markets—pooling demand to secure lower prices, ensure reliable supply, and expand access to vaccines and essential medicines. Although these funds are a major regional asset, there is

broad agreement that these structures require modernization, adaptation, and expansion to aggregate demand more effectively across regions and unlock the region’s full negotiation potential. Moreover, there are missed opportunities for pooled supply of regional public goods: fragmentation prevents collective investments (regional vaccine production, joint R&D, a regional Center for Disease Control [CDC]) that would strengthen supply security and regional autonomy.

Technical cooperation: This remains a strong pillar of the current global health architecture; however, it could be reconfigured so that this function is increasingly carried out by national institutions, rather than primarily by technical staff in global or regional bodies such as WHO or PAHO.

Reimagining the Architecture: Functions and Forms

Much of the discussion about functions and forms of a reimagined architecture gravitated toward what can realistically be achieved at the regional level—an emphasis that likely reflects the region’s current position within the global health architecture. Participants noted that regional bodies are the mechanisms they know best and interact with most frequently, whereas global institutions often feel distant, slow, or insufficiently attuned to local priorities.

This orientation is also linked to the region’s self-perception that it possesses sufficient capacity to solve its own challenges and to support countries both within and beyond LAC. Participants argued that the region has ample internal expertise and practical experience to drive meaningful improvements, particularly if mechanisms for systematic peer learning and exchange are strengthened.

For many countries, especially those not reliant on substantial external financing, the day-to-day experience of governance, coordination, and technical support is mediated far more by regional entities than by global ones. This practical reality shaped the dialogue: proposals for reform tended to focus on enhancing regional capacities and cooperation, even as participants acknowledged the continued need for effective global engagement. However, viewed from another angle, several regional strengths and initiatives could serve as models that may be adopted or scaled up at the global level. There were four key proposed changes to reconfigure the functions and forms of a new architecture.

1. Refocus Global Mandates

- WHO and PAHO should focus primarily on core, centralized functions such as stewardship, norm-setting, policy guidelines, international advocacy, and coordinating emergency response. This shift would devolve technical cooperation and capacity-building functions to the regional level, where they can be handled more appropriately.
- Another idea proposed was refocusing the mandate of multilateral development banks toward long-term health system strengthening, including consolidating global financing streams so that a single multilateral bank—rather than multiple parallel institutions—provides coordinated support for this function.

- The regional level should concentrate on leveraging economies of scale and strengthening regional public goods through joint procurement mechanisms; coordinated production of health commodities and services; regulatory harmonization; South-South cooperation; and emergency response capacity. Participants emphasized that such regional agreements must be binding and sustained, not merely declarative.
- At the national level, governments must lead domestic health financing efforts, working to reduce inequalities and ensure universal access while strengthening state stewardship and accountability to citizens. Participants agreed that although fiscal margins are limited, domestic investment in health—including concessional loans from development banks—is essential; external cooperation can only play a complementary role.

Box 2. PAHO at a Crossroads: Key Regional Tensions

One constant emerged in the dialogue: sustained reflection on PAHO’s role and whether its mission and functions should be redefined for the future or maintained as they are.

Areas of Broad Agreement

1. Modernization and Reduced Bureaucracy:

Stakeholders agreed that PAHO must break with the status quo and modernize its structures, reduce cumbersome processes, and strengthen sustained in-country capacity rather than rely on short-term external consultants.

2. Decentralization and Proximity to

Countries: There was strong agreement on the need for PAHO staff—initially trained in countries—and headquarters office to return to the region, ensuring greater responsiveness and alignment with local realities.

3. More Inclusive Governance and Advocacy:

Dialogue participants support increased participation of civil society and academia in governance and advisory functions to enhance legitimacy, accountability, and advocacy.

Areas of Disagreement

1. Divergent Regional Experiences: Caribbean countries report highly positive engagement with PAHO, while Latin American countries—especially larger ones—perceive PAHO as distant and overly uniform (“*painting the region with the same brush*”). This divide stems largely from PAHO’s operational model in the Caribbean, which is different from the strategy in other countries, where each island has a dedicated coordinator, often embedded in the Ministry of Health. This “deep-connection philosophy” generates trust, rapid responsiveness, and strong perceived value.

2. Uneven Power and Participation: The Caribbean values PAHO’s advocacy in global forums, where small states struggle to be heard, but at the same time participate less in formal governance (e.g., PAHO’s Directing Council). This contradiction raises concerns about the small states influence over PAHO’s strategic decisions.

3. Reform Sensitivities and Dependency: The idea of reform may be interpreted by some in the Caribbean as a threat to the one-country-one-vote system where the subregion holds more weight than LAC. Some countries—particularly small islands—fear losing current benefits through reform. A broader paradox also persists: Member States have the authority to demand reform but depend on PAHO’s support, weakening incentives for change. This issue remains unresolved.

2. Decentralize Governance

A major thrust of the reform movement is redirecting decision-making power away from centralized global institutions toward regional and national mechanisms, recognizing that public health requires local capacity and leadership. To this end:

- Global structures should support regional leadership without overshadowing local capacity. Additionally, to enhance countries' representation in the global debate, boards of all global health initiatives should include representatives of the countries served (some institutions already do this). The region as a whole should also reactivate or generate new spaces for more meaningful participation in the global debate.
- Large multilateral institutions must right-size and become more agile, act as catalysts for innovation, and provide national actors with greater influence in shaping regional and global health agenda. This also implies a more inclusive and transparent governance model: representation in the governing bodies of multilateral institutions should extend beyond governments to systematically include civil society, academia, users, and patient groups in monitoring, policy development, and decision-making. Transparency in financing, staffing, and performance should be significantly strengthened to build public trust and ensure that institutions remain accountable to countries and citizens.
- Academia should play a central role in generating evidence and providing independent analysis, while civil society, communities, and patient organizations must be involved in monitoring progress and contributing to policy development. One way to move forward is for academia to join efforts for specific projects (such as the one carried out by the consortium of universities on this project); a more sustainable approach in the long run would be for a set of institutions, grouped under the LAC Innovation Hub (see below) to lead joint efforts.
- To avoid repeating the shortcomings of the current architecture, the reformed system must be governed by binding rules with clear consequences for non-compliance (or alternatively, a well-designed incentive system), rather than informal arrangements based on personal relationships or goodwill.

Box 3. Improving LAC's Position within the Current Architecture

- **Strengthen regional identity and solidarity by fostering shared narratives** that reflect Latin America and the Caribbean's diverse but interconnected realities.
- **Develop common regional agendas:** LAC must unify and coordinate its political position to present a strong force globally, recognizing that health diplomacy requires inserting health concerns into the broader agendas of high-level forums like the G20.
- **Institutionalize cross-subregional coordination through regular, structured platforms** linking the Caribbean Community (CARICOM), the Central American Integration System (El Sistema de la Integración Centroamericana, or SICA), the Andean Community, Mercosur, and other regional mechanisms.

3. Rebuild Global Health from the Regional Level

Strengthening the global health architecture increasingly depends on what happens at the regional level. Regions are where political priorities converge, where coordination is most immediate, and where institutions have the contextual knowledge to provide timely support. In LAC, participants emphasized that meaningful

global reform must build on strong regional cooperation—both to address shared challenges and to amplify the region’s voice in global decision-making. By reinforcing regional mechanisms and leveraging local expertise, countries can contribute to a more coherent, responsive, and equitable global health system.

The following initiatives, although not necessarily reflecting consensus at the regional level, were derived from the Dialogue, proposed in the interviews, discussed in the webinars, and polished during the convening as potential contributions for improving regional and global health architecture. Key reform proposals to reinforce the regional health architecture to this end included a regional platform for health cooperation (LAC Health Catalytic Platform, or LAC-HCP) and the creation of a regional health innovation hub (LAC Innovation Hub).

Box 4. LAC Innovation Hub

This proposal builds on the considerable capacities that already exist within countries across the region—capacities that are often underutilized or insufficiently recognized by others. Barriers such as limited platforms to showcase expertise, the absence of mechanisms to facilitate cross-country knowledge transfer, and inadequate financing for South–South technical cooperation hinder their full potential. The LAC Innovation Hub would:

- Work through annual calls for proposals
- Establish regional priorities through a Regional Committee
- Leverage and expand existing capacities through structured country-to-country exchanges
- For instance, two countries in the region could submit a joint proposal to exchange knowledge and practical technical experience in digital information systems and interoperability or quality improvement in healthcare services.

Box 5. LAC Health Catalytic Platform (LAC-HCP)

This proposal advances the creation of a regional platform for health cooperation (LAC-HCP) to reshape and strengthen the region by fostering collaboration and enabling coordinated investment. The platform would operate as a unifying, non-duplicative mechanism, fully complementary to the mandates of PAHO, subregional mechanisms, and multilateral development banks. The platform would support two distinct but interconnected domains of cooperation:

Development of regional public goods (RPGs):

- Health data architectures, digital health standards, and interoperability
- Health technology assessment (HTA) methodologies and evidence platforms
- Shared generation and analytical capacities for AI-powered data-driven solutions for healthcare, research and surveillance, early warning systems, and policy implementation science
- Regional guidelines, capacity-building programs, and knowledge repositories accessible to all countries

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South-to-South cooperation for shared production and services (non-RPG goods):

- Joint/ coordinated procurement of medicines, vaccines, diagnostics, and devices
- Regional manufacturing of pharmaceuticals, biologics, and other health goods
- Shared regulatory strengthening, pooled demand forecasting, and supply-chain integration
- Collaborative service models such as capacity building, technical assistance, or digital health deployments

4. Unlock Sustainable Financing

To ensure long-term, equitable, and efficient health system financing, reforms are needed to mobilize additional resources through innovative financing mechanisms, optimize resource use through strategic purchasing, and strengthen the contributions of global actors by improving the financial and governance architecture.

4.1 Innovative Revenue Collecting Mechanisms

- **Taxes on harmful products:** There is openness and broad consensus regarding the imposition of taxes on products harmful to health (tobacco, alcohol, sugary drinks, ultra-processed foods). This idea was discussed as a strategy to increase health revenue at the country level, as well as a way to contribute to a regional fund.
- **New sources of regional revenue:** Suggestions included increasing tourism-related taxes, taxing residual profits of large multinationals, and exploring a multilateral investment model applied to the health sector that generates dividends for participating countries.
- **Local and regional philanthropy:** Coordinate local philanthropic foundations (which currently invest only domestically) to support regional programs. Promote fiscal simplification of social responsibility schemes to boost local and regional philanthropy.
- **Private investment and venture capital:** Explore venture capital mechanisms for health innovations that can generate returns and promote reinvestment. The proposal calls for the integration of all sectors, including chambers of commerce, industry, and tourism.

Box 6. Create the Catalytic Regional Solidarity Fund

- The proposal envisions the creation of a pooled, catalytic financing mechanism in which multilateral development banks would coordinate and leverage existing regional health funds. The mechanism rests on three core principles. First, efficiency—achieved through pooling resources from multiple donors, reducing administrative costs, and spreading financial risk. Second, solidarity—by allocating funds where they are most needed to support regional functions and cooperation, particularly as many countries no longer qualify for traditional aid. Third, strengthened domestic commitment—by using regional financing to bolster national investment in shared priorities and regional initiatives.
- The mechanism could be capitalized through health-related taxes (e.g., on tobacco) and by redirecting surpluses or unutilized balances from existing multilateral projects, thereby expanding the region's

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Create the Catalytic Regional Solidarity Fund, continued

capacity to finance joint actions and promote regional health outcomes. The fund should be governed by a board that includes country representatives and is hosted in one of the existing multilateral banks, to leverage their expertise in managing these types of initiatives.

- Although unclear, some potential uses for this fund include financing regional public health goods, generating a regional emergency response, and supporting regional market-shaping strategies or joint production of health goods and services.

4.2 Strategic Purchasing

- **Loan guarantees as an effective credit-enhancement tool to lower borrowing costs for LAC countries:** While some philanthropists already use this instrument, there is significant potential for expansion through regional philanthropists and multilateral banks—e.g., the Inter-American Development Bank (IDB), the Development Bank of Latin America and the Caribbean (CAF), or the Central American Bank for Economic Integration (BCIE)—to mobilize additional financing for health. Also, discuss the implementation of debt swaps or debt-for-development (D4D) swaps.
- **Catalytic, results-based financing:** Link financing to specific and measurable achievements in areas with high return on investment and associated with quality goals (e.g., surgical waiting times for breast cancer).
- **Regional and contingency funds:** Establish regional emergency funds to enable rapid response to health crises. This is one of the potential uses of the regional solidarity fund. Also, design pre-approved “peace-time” instruments for pandemic response that can be activated immediately without negotiation during a crisis.
- **Shift health insurance models toward wellness and prevention:** Shift from a treatment-only approach to one that actively funds and incentivizes wellness and preventive care, including routine check-ups. Although this requires initial investment, evidence shows it reduces long-term costs by lowering the burden of chronic disease.

4.3 Reform of Financial and Governance Architecture

- **Reform of multilateral banks:** The concept of fair international financing was proposed, with participants emphasizing that institutions such as the World Bank, the IDB, and CAF should focus on long-term financing for structural reforms, rather than on isolated or short-term programs.
- **Revision of graduation criteria:** It is essential to review the use of income as the main criteria for eligibility of concessional financing or health assistance. The current system labels countries (such as SIDS) as high-income, without accounting for their particular vulnerabilities to climate change.
- **Broaden the health agenda:** Additionally, several participants emphasized the critical need to integrate health with the economic agenda. They recognized that health depends not only on economic stability but also actively contributes to growth, productivity, and social well-being, creating spillover benefits for education, employment, and social cohesion.

Reform Pathways

The insights gathered through the dialogue point to several potential pathways for putting the proposed functions and institutional forms into practice. The proposed step-by-step reform process is ambitious, beginning with the recognition that incremental change from within the current global health institutions has repeatedly failed. Instead, the pathway must be regionally led and anchored in strong political commitments.

Step 1. Secure high-level political and financial leadership for reform

The first step is to secure the political and financial levers needed to advance reform, recognizing that change will not come from within institutions that would need to give up power. The momentum must be generated by the region (not the regional “institutions”) and driven by political actors with the authority to push for global debates. This involves identifying and empowering high-level champions—heads of government, influential ministers, and regional leaders such as the CARICOM lead head for health—and equipping them to advocate for a LAC-driven reform agenda (e.g., at the Summit of Americas 2026, the World Health Assembly, the UN General Assembly, and the PAHO Directing Council Meeting). In parallel, the region must build durable political and financial coalitions that transcend electoral cycles. Engaging ministers of finance is essential to strengthen the economic case for health and ensure sustained support. To protect commitments over time, countries should explore legal or constitutional instruments that guarantee continuity and enable the creation or strengthening of regional mechanisms.

A critical component of this step is forging alliances beyond the region by identifying shared interests with other blocs and partnering with countries that carry weight in global forums such as the G20, G7, and BRICS. These alliances can amplify LAC’s voice, expand political leverage, and help push for reforms in global spaces where the region is often underrepresented. Collectively, these actions create political ownership, financial backing, and international alignment required to drive and sustain a credible reform agenda. One strategy would be to leverage LAC’s political visibility in these new health spaces at existing regional health conferences or summits such as the PAHO regional assembly or annual conferences of the World Bank, IDB, or CAF, among others.

Step 2. LAC Health Catalytic Platform

To prepare for implementation of a LAC Health Catalytic Platform (see Box 5), selected regional academic institutions should be commissioned to conduct a comprehensive stakeholder mapping, political economy analysis, and strategic roadmap, gathering insights from governments, civil society, private sector actors, and technical organizations. The platform’s financing architecture will be sustained through catalytic resources, combining: (1) a trust fund or guarantee mechanism; (2) costing and financing strategies for RPGs; and; (3) enhanced joint procurement and regional production models.

Funding would come from multilateral development banks (IDB, the World Bank, CAF), philanthropic organizations, and—critically—domestic funds from LAC countries, ensuring ownership, legitimacy, and long-term sustainability. Coordinating and pooling existing funds before jumping into looking for new sources can help generate resources for financing these initiatives.

The LAC-HCP platform represents a transformative opportunity to build a more resilient, efficient, and collaborative regional health ecosystem that leverages shared strengths while generating goods and capacities that no single country could achieve on its own.

Step 3. LAC Innovation Hub

To achieve the implementation of a LAC Innovation Hub (see Box 4), the following steps and milestones were proposed:

- Based on the discussions held at the convening, the Dominican Republic, Colombia, and Brazil could initiate preliminary discussions with PAHO to launch and shape the design of the initiative.
- PAHO would serve as the technical and operational coordinator of this initiative through a dedicated, agile ad-hoc working group operating under the strategic mandate of a Regional Committee composed of governments, academia, and civil society, responsible for defining the annual regional priorities. The working group would identify institutions and governments interested in joining the Regional Committee.
- In line with the health exchange priorities set by the Regional Committee, a regional mapping of national experiences would be undertaken and consolidated into an Information Repository to facilitate systematic knowledge exchange.
- Annual calls for proposals would be issued to enable countries to identify shared priorities and apply as a tandem to provide and receive technical cooperation. The PAHO ad-hoc working group would develop the terms of reference for these calls.

This initiative requires dedicated funding and a transparent, participatory governance approach, with academia and civil society playing central roles in monitoring and evaluation (M&E).

Step 4. Sustainable financing for health

Improving health financing in the region requires a phased and pragmatic sequence of actions. The first step is to coordinate/ optimize existing mechanisms by modernizing PAHO's Revolving Fund and Strategic Fund and expanding pooled procurement across regions, generating significant price reductions and demonstrating early progress towards improved access to quality drugs and medical devices. This can also be fostered by the establishment of the Regional Solidarity Fund. Simultaneously, countries can move toward sustainable domestic and regional revenue through innovative taxation—such as sin taxes, tourism levies, and digital service taxes—and channel a share of these resources into new regional health funds. With predictable public revenue in place, the region could safely mobilize private and non-traditional capital through public–private partnerships, impact investment, pension fund allocations, and regional insurance schemes, widening the resource base for system strengthening. These flows should then be guided by performance-based financing, debt-reduction incentives, and earmarked allocations for prevention to ensure effective use of funds. Finally, long-term continuity requires anchoring reforms in legislation or regional agreements, decoupling financing from decision-making power, and redefining institutional roles so that global bodies focus on stewardship while regional actors lead implementation. Together, this sequence moves the region from quick wins to structural transformation and builds a financing system that is sustainable, autonomous, and aligned with LAC priorities.

To continue the global health architecture dialogue

Beyond these specific pathways, sustaining reform requires maintaining (post-reform) political engagement and regional coherence. Participants emphasized *“Without real political influence, including presidents and finance ministers, it’s difficult to influence national agendas.”* This necessitates empowering high-level champions, such as CARICOM’s lead head for health and influential ministers, to advocate in regional summits (Mercosur, the Community of Latin American and Caribbean States [CELAC], SICA, the Andean Health Organization – Hipólito Unanue [ORAS-CONHU]) and global forums (G7, G20, and the World Climate Summit [COP]).

Health must integrate with climate, trade, and economic strategy through “Health in All Policies” frameworks linking finance, infrastructure, commerce, and environment ministries to health outcomes. Engaging civil society, academia, patient organizations, and the private sector requires transparent governance and accountability—not *“declarations of good intentions.”* Anchoring reforms in legislation, decoupling financing from decision-making, and establishing binding mechanisms ensures continuity beyond political cycles. Engaging ministers of finance is especially critical to align health investments with macroeconomic goals and overcome persistent gaps in coordination.

Conclusion

LAC is well positioned to play a decisive role in shaping the next generation of global health reform. The region brings a long-standing tradition of solidarity, successful models of pooled procurement, strong public institutions, effective policies to counter commercial determinants of health, and deep experience managing health challenges across political and economic contexts. This collective leadership would allow the region to champion reforms that center equity, strengthen regional autonomy, and align global health priorities with the realities faced by unequal middle-income countries.

The global health crisis reflects a wider breakdown in geopolitics and international cooperation. It cannot be solved by one single sector (health) or a single country. Participants in the LAC dialogue noted that health outcomes are increasingly shaped by financial pressures, political tensions, requiring sustained engagement and collaboration, as well as broader governance reforms at national, regional, and global levels. Building this capacity is essential for ensuring that health concerns are integrated into broader policy debates and that the region can influence agendas that directly affect population health.

By advancing regional self-sufficiency, deepening South-South cooperation, and embedding health within broader economic and climate strategies, LAC can help drive a more balanced, responsive, and legitimate global health architecture. In doing so, the region can not only transform its own health future but contribute meaningfully to a global reform effort that benefits all regions.

Disclaimer: This paper captures the outcomes of one of five regional dialogues supported by the Wellcome Trust and led by regional partners. The views and opinions expressed throughout the dialogue are those of individual participants, and do not necessarily reflect the official policy or position of Wellcome.



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