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Resetting the Global Health Architecture:
A Simpler, Fairer, and More Accountable System

Position Paper
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The global health architecture is facing a moment of structural strain. Funding volatility, geopolitical fragmentation, climate pressures, demographic change, and the lessons of the Covid-19 pandemic have exposed a system that is overly fragmented, dependent on a small number of donors, and insufficiently aligned with local priorities for long-term health system resilience.

Several features increasingly characterise the contemporary system:

- **Global health governance operates through numerous institutional centres.** Multilateral organisations coexist with specialised partnerships, financing mechanisms, philanthropic agencies, regional health bodies, national institutions, the private sector and other actors. This plurality reflects the historical evolution of global health cooperation rather than a single institutional design of the architecture.
- **Authority is distributed.** Different institutions perform specialised functions including financing, technical guidance, research, and implementation. Governance depends on cooperation and synergies across these organisations yet is often characterised by competition and fragmentation.
- **Sovereignty concerns exist.** Across Africa in particular, governments, regional organisations, scholars and commentators have emphasised the importance of regional and national leadership in priority setting, research governance, and health system development.
- **Accountability cannot rely solely on hierarchical authority.** Instead, in a distributed governance environment, legitimacy emerges through mechanisms that support coordination, participation, trust, and transparency.

Incremental reform is no longer sufficient. A fundamental reset is required to create a simpler, more coherent, and more equitable global health system.

Following two expert discussions convened by the All-Party Parliamentary Group (APPG) on Global Health & Security with multilateral leaders, regional experts, civil society representatives, and academic specialists, a clear set of reform priorities has emerged. These discussions point toward a streamlined architecture with clearer institutional mandates, stronger regional leadership, and sustainable financing, anchored by a revitalised, lean and focussed World Health Organization.

The Central Role of the World Health Organization

A reformed global health architecture should place the World Health Organization (WHO) at the centre of the system in a strengthened normative and coordinating role. In February 2026, the Executive Board of the World Health Organization adopted decision EB158(20) requesting the Director-General to develop a proposal for a joint process addressing the future of global health governance, to be presented to the Seventy-ninth World Health Assembly in May 2026.

The APPG asserts that, rather than acting as a large-scale programme implementer, WHO should focus on five core pillars that underpin effective global health governance.

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1) **Technical guidelines and standards:** WHO should remain the world's authoritative body for developing technical guidance, clinical protocols, and international health standards. Clear, evidence-based guidelines help ensure consistency in treatment approaches, regulatory practices, and public health responses across countries.

2) **Early alerts and risk monitoring:** WHO should act as the global hub for early warning systems, identifying emerging health threats and communicating risks rapidly to governments and international partners. A strengthened alert system will allow countries to respond more quickly to outbreaks and other public health emergencies.

3) **Pandemic preparedness and coordination:** WHO should lead global preparedness planning and coordinate international responses during major health emergencies. This includes supporting pandemic preparedness frameworks, facilitating cross border cooperation, and ensuring that response mechanisms are triggered quickly and transparently.

4) **Medicine regimens and treatment protocols:** WHO plays a critical role in defining recommended treatment regimens for infectious diseases and other priority conditions. Maintaining authoritative global guidance on medicines, vaccines, and therapeutic protocols helps ensure that countries have access to trusted, scientifically validated approaches to treatment and prevention.

5) **Data, surveillance, and monitoring:** A robust global health architecture requires reliable data. WHO should serve as the central platform for global disease surveillance, health data collection, and monitoring of health outcomes. Strengthened data systems allow for more effective policymaking, better accountability, and improved preparedness for future crises.

A leaner WHO[1] does not mean a weaker WHO. Instead, a more focussed mandate would strengthen the organisation's authority in these areas and reinforce its role as the steward of the global health system.

A lean WHO with a clear mandate needs flexible funding, with clear annual key performance indicators (KPIs), to deliver effectively and ensure value for money to donor countries. The UK government should be praised for its flexible funding, but it can't do so alone, and it should take a leadership role to encourage other countries to provide this.

Simplifying the Institutional Landscape

Reform should focus on reducing duplication and clarifying the roles of key institutions rather than creating new global bodies.

Greater alignment is needed between multilateral financing mechanisms, development banks, and technical agencies. Existing partnerships such as Gavi and The Global Fund have delivered major health gains, but coordination between institutions must continue to improve, particularly at country level. Furthermore, any reform process should explore strategic governance oversight by the WHO of these key institutions, providing direction on integration and mutually beneficial ways of working.

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[1] The APPG is aligned with analysis by the Center for Global Development (CGD) which proposes the following efficiency savings:

1) Reducing the WHO's extensive technical assistance work in countries, with exceptions for outbreak and pandemic response.
2) Consolidation of WHO technical centres to a centralised model at the Geneva headquarters or regional offices.
3) More effective prioritisation, possibly through a member state committee focussed on achieving most effective global public goods.

See full CGD analysis: https://www.cgdev.org/sites/default/files/lean-world-health-organization-global-good.pdf

The objective should be a system in which institutions complement one another rather than compete or overlap.

Financing Reform for Long-Term Sustainability

Sustainable health systems require a shift from short-term programme funding toward long-term investment in health systems and global public goods. Architecture reform should prioritise:

- Backing national priorities and national health sovereignty.
- Stronger domestic health financing of top priorities, with aid topping-up.
- Focusing grants on the lowest income countries that need it most.
- Greater use of loans and blended finance approaches for middle income countries.
- Investment in global public goods such as surveillance, vaccine research, and antimicrobial resistance response.
- More efficient and transparent use of international funding.

Health should increasingly be treated as a long-term public investment rather than a cost. Multilateral Development Banks are uniquely placed to do this, providing long-term resources directly to governments to back their national priorities.

Rebalancing Power Through Regional Leadership

Global health architecture reform must also redistribute power more equitably across the global system. Regions and country groupings should play a stronger role in priority setting, knowledge generation, and technical cooperation.

This includes strengthening regional research institutions, improving data capacity, and ensuring that governance structures reflect the realities of fragile states, displacement, and demographic change. Regional approaches should remain flexible and locally defined rather than imposed through rigid global templates.

Engaging Diaspora and Civil Society

Diaspora communities and civil society organisations are an underutilised resource within global health governance. Greater engagement could include:

- Formal advisory mechanisms linking diaspora health professionals with policy processes.
- Participation in international consultations on global health reform.
- Digital training partnerships and telemedicine programmes connecting diaspora expertise with health systems in partner countries.

These networks can help bridge knowledge gaps, improve policy relevance, and strengthen trust between institutions and communities.

A Simplified and More Accountable System

The APPG proposes that reform be guided by six principles:

1) **Simplicity:** The global health system should reduce unnecessary complexity, duplication, and overlapping mandates across institutions. Clearer division of responsibilities between global organisations, financing mechanisms, and regional actors will lower transaction costs for countries and improve the efficiency and transparency of international health efforts.

2) **Subsidiarity:** Decisions should be taken at the lowest effective level of governance. National governments, regional institutions, and local actors should lead where they have the capacity and legitimacy to do so, while global institutions should focus on functions that require international coordination or collective action.

3) **Stewardship:** The World Health Organization should act as the central strategic steward of the global health system. Its role should focus on leadership and convening, setting technical guidelines and standards, coordinating global surveillance and early alerts, strengthening pandemic preparedness, providing authoritative guidance on medicine regimens, and maintaining global health data systems.

4) **Sustainability & Sovereignty:** Global health financing must be designed for long-term resilience rather than short-term programme delivery. This includes putting national priorities at the centre, with domestic health financing of the top priorities and aid topping-up, focussing grant funding on the poorest countries and blending with loans for richer countries. This must be supported by international investment in global public goods such as surveillance systems, vaccine research, and antimicrobial resistance responses.

5) **Solidarity:** Global health governance should reflect equitable participation and shared responsibility across countries and regions. This requires meaningful representation for Global South institutions, civil society organisations, and diaspora communities in decision making processes that shape global health priorities.

6) **Accountability:** Institutions and financing mechanisms within the global health architecture should operate with clear performance metrics, transparent reporting, and mechanisms for monitoring progress. Stronger accountability will help ensure that investments deliver measurable improvements in health outcomes and system resilience.

A simplified architecture anchored by a strengthened lean World Health Organization, supported by aligned multilateral institutions and empowered regional actors, which work together to support strong national health systems, offers the most credible pathway to a more resilient and equitable global health system fit for the challenges of the coming decades.

Actions for UK and International Parliamentarians

The credibility of WHO's process will depend on its ability to engage the full range of actors, including regional institutions, global health partnerships, diaspora and civil society organisations, research communities, and the private sector, while addressing questions of sovereignty, representation, and asymmetric power.

The UK Government, Members of Parliament and their international partners have an opportunity to accelerate this governance discourse. The APPG on Global Health & Security recommends that policymakers:

1) **Champion governance reform for a polycentric but coherent system.** The UK should promote reforms that recognise the distributed nature of global health governance while reducing duplication and clarifying institutional mandates. Reform efforts should prioritise transparency in financing, clearer division of responsibilities across institutions, and stronger coordination mechanisms across the system.

2) **Strengthen the stewardship role of the World Health Organization.** The UK should publicly support a lean WHO centred on its core global functions outlined earlier in this position paper. To enable this role, the UK should continue to champion increased flexible and predictable

funding for the WHO and build an international coalition of donors committed to strengthening the organisation's financial base.

3) **Support stronger regional leadership within global health governance.** Recognising growing calls for regional ownership, particularly across Africa, the UK should engage constructively with regional institutions and support efforts to strengthen regional leadership in priority setting, research governance, and health system development. This should include deepening partnerships with organisations such as the African Union to ensure regional actors play a greater role in shaping the future global health architecture.

4) **Address structural imbalances in global health capacity.** The UK should support initiatives that reduce asymmetric power relationships across the global health system, particularly in research capacity, technological development, and access to financing. Strengthening regional research institutions, improving data systems, and expanding technical cooperation will be essential to creating a more equitable and resilient architecture.

5) **Align international financing with long-term country-led health system resilience.** Global health financing should move away from fragmented short-term programmes toward sustained investment in health systems and global public goods. The UK should use its influence with multilateral development banks and global financing mechanisms to promote financing models that support national priorities, strengthen domestic health financing, and focus limited international grant resources on the poorest countries.

6) **Promote responsible governance of emerging health technologies.** As digital health systems and artificial intelligence become more integrated into healthcare delivery and surveillance, the UK should support international cooperation to develop transparent and equitable governance frameworks. These frameworks should ensure that emerging technologies strengthen the human economy of health and care while safeguarding trust, accountability, and patient safety.

7) **Mobilise UK diplomatic influence to advance reforms.** The UK should actively advance these reform principles in major international forums, including at the World Health Assembly and at the Global Partnerships Conference being hosted by the UK Government in May 2026. The UK should also use its financial contributions and governance roles across multilateral institutions to promote greater alignment with the principles outlined in this position paper.

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