

Four paradigm shifts to shape an agenda for global health reforms



Struck by substantial funding cuts throughout 2025, the global health community stands at a crossroads.¹ Notwithstanding the grave consequences of decreased international financing, this crisis offers an unprecedented chance to address the well known flaws in the current system. Although the notion that we should first stabilise and later transform the global health landscape has gained traction, it fails to recognise that the present sense of urgency is precisely what makes systemic change possible, and that those two processes should therefore happen in tandem. Immediate responses cannot be siloed from the long-term outlook. Many global health reform discussions are already well underway, but they remain dispersed, without shared vision and legitimate leadership.²⁻⁷ For these diverse perspectives to come together, a common framing and understanding of prevailing issues and current opportunities is needed (panel).

We suggest four paradigm shifts and propose they could serve as a high-level framework to guide collective thinking and subsequently drive concerted political actions and tangible reform and health outcomes.

The first shift is about recognising the fundamental changes in the global burden of disease and in demography. Threats such as malaria, tuberculosis, and AIDS dominated the Millennium Development Goals (MDGs) era (2000–15), whereas non-communicable diseases and mental health disorders are now the main causes of death in many low-income countries and high-income countries alike.⁸ Out of more than 43 million deaths caused by non-communicable diseases globally, around 73% are in low-income and middle-income countries.⁹ Risk factors for poor health are also evolving rapidly and increasingly originate outside the health-care sector, including those arising from climate change, urbanisation, and commercial factors.^{10,11} However, structures and priorities within the global health ecosystem remain clustered around infectious diseases and the MDGs. While addressing infectious diseases continues to be important, a reformed ecosystem should adapt to notable epidemiological shifts, strengthen integrated prevention and services, enhance health promotion, and approach health through cross-sector collaboration. To this end, functions of the global health system should be

re-prioritised, and the global health institutions reformed, in line with the changing disease burden.

The second shift relates to the recentring of power from Geneva in Switzerland and New York and Washington in the USA to countries and regions, giving rise to an increasingly multipolar world—for example, regional centres for disease control and prevention are increasingly important hubs for procurement of medical countermeasures and for coordination of public health efforts.¹² This changing locus of power is multifactorial, and is driven by demand for equity, sovereignty, and self-reliance, coupled with growing local capacities and financial resources.¹³ This shift does not imply that multilateral cooperation is obsolete; however, it requires a clarification of which future functions should be performed at the global level and which should be performed by national and regional bodies (eg, technical assistance). Considering the changing roles and power dynamics, the mandates of global health organisations, including WHO, should be revisited in the new ecosystem, ensuring that organisations focus on their remaining global comparative advantages. These advantages could include surveillance, norm-setting, and market shaping, although this is not an exhaustive list. Overall, the

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Panel: Discourse so far: fragmented reforms for a fragmented system?

Various perspectives on global health reforms have been articulated, contributing to a continuously evolving landscape. As of now, the most prominent voices have come from Africa and Europe. The overarching sentiment has been that the current financing crisis should be viewed as an opportunity for positive change in global health. Leaders in Africa have acknowledged the need for continued international finance, but have underscored preference for partnerships built on co-creation rather than on a donor–recipient basis, stressing that each country should gradually take on a larger share of its own health financing. By contrast, a handful of traditional development partners have spoken of stepping up and taking responsibility for global health, with less emphasis on rethinking the partnership model. However, such pledges, along with the persistent use of language grounded in the aid framework, risk reinforcing the very system leaders in Africa are attempting to reset.

The insufficient co-ordination and amount of common objectives could stall the reform progress and threaten its success. Importantly, coordination restricted to like-minded groups will not suffice, and alignment across actors is needed, especially given the uneven distribution of resources, influence, and legitimacy shaping the current discourse. Additionally, amid the pressure to adapt to the current austerity environment, there is a risk that organisations will prioritise short-term cost-containment strategies over strategic restructuring.

number of functions of the global health system should be reduced, with a focus on global common goods (eg, health standards and pandemic preparedness).

The third shift refers to the growing push to modernise the landscape of global health institutions. Leaders from low-income and middle-income countries have repeatedly critiqued the dearth of systemic support, the inefficiencies of vertical initiatives, and the resource-intensive bureaucratic processes that accompany them.¹⁴ Moreover, shrinking budgets in global health have sparked debates around consolidating functions (eg, to increase efficiency or avoid duplication) and sunseting certain global health institutions.¹⁵ Considering these external and internal pressures, there is a need to move from a complex and competitive system to a simpler, needs-based, and agile system. This move warrants functional accountability mechanisms within and real change across the UN, global health initiatives, funds, and public-private partnerships. This change could require a narrowing of the mandates of global health institutions and pursuing efficiencies, including through potential mergers.

The fourth shift is linked to the declining relative importance of development assistance, coupled with countries' rising commitments to increase domestic financing for health. Although some international support will remain essential for low-income countries and humanitarian responses, domestic resources must be the engine of a new ecosystem and ways of working together. This self-sufficiency necessitates continued economic development through sustainable financing approaches, including progressive general taxation, more effective corporate taxes backed by global treaties, and addressing illicit financial flows. Major determinants of fiscal space for health do not lie within the health sector itself, and instead span trade conditions, debt structures, and power distribution within the international financing architecture.¹⁶ As we move away from the aid-based framework and towards health sovereignty, the future global health system must also adopt new ways of funding global-level functions, subject to defining what those functions are.

The four paradigm shifts are highly interdependent and should thus be considered jointly. The shift in disease burden is linked to countries transitioning from low-income to middle-income status and the accompanying changes in life expectancy, epidemiology, determinants of health, and health-care needs.¹⁷ Greater economic

capacities are not only reshaping health-care needs but are also making countries less reliant on external sources of health financing, thereby fuelling the shift in power. As national health expenditures grow, global functions based on cash and in-kind transfers will inevitably decline in importance. Instead, future global functions should be restricted to issues that no country can tackle alone and should complement, rather than duplicate, country-led and region-led efforts. This approach calls for a substantial redesign of the present institutional landscape, including the number of organisations, the scope of their mandates, and the way they are financed. A global health system that is truly shaped by evolving health needs, more equitable power distribution, and shared interests cannot be sustained by aid. Rather, a reformed system should be funded by collective government investment, reflecting the mutual benefits that underpin its remaining functions. In conclusion, the momentum to build a more fit-for-purpose international ecosystem is the silver lining in this otherwise bleak time for global health. Meaningful change now hinges upon genuine partnerships between all countries, prioritisation of pragmatic political pathways, and leveraging novel fora, despite the volatile geopolitical climate.

We believe that the future global health system should reflect the suggested four paradigm shifts by design. These shifts can thus serve as a valuable overarching compass for joint global health reform efforts, steering the conversation from what needs changing to how to do it in practice.

AN is a board member of the Alliance for Health Systems and Policy Research, has served as a paid consultant to Hyphen Ltd and WHO Western Pacific Region; and received honoraria from the International Vaccine Institute for participation in the Global Advisory Group of Experts. PP has received grants (to institution) from the Gates Foundation and the Independent Advisory Committee of the Global Burden of Disease; received consulting fees from the Gates Foundation; has participated on the independent advisory committee of the Global Burden of Disease, PREPARE Singapore International Advisory Panel, and Pasteur Network Strategic Advisory Board; and reports paid roles on the boards of Biocon Biologics, Biological E, and Vestergaard. All other authors declare no competing interests.

**Anders Nordström, Magda Robalo Correia e Silva, Helen Clark, Ren Minghui, Peter Piot, Yik-Ying Teo anders.nordstrom.2@ki.se*

Karolinska Institutet, Stockholm 171 77, Sweden (AN); Stockholm School of Economics, Stockholm, Sweden (AN); Institute for Global Health and Development, Bissau, Guinea-Bissau (MRCeS); The Helen Clark Foundation, Auckland, New Zealand (HC); School of Public Health, Peking University, Beijing, China (RM); London School of Hygiene & Tropical Medicine, London, UK (PP); Saw Swee Hock School of Public Health, National University of Singapore, Singapore (Y-YT)

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Hospitals as tenants: the rise of real estate investment trusts in health-care delivery

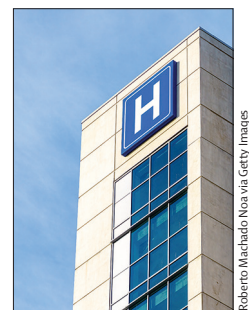


As financial actors including private equity funds increasingly buy and sell hospitals, nursing homes, and physician practices, real estate investment trusts (REITs) have emerged as a form of financial ownership in which the REIT owns the real estate properties of health-care facilities and health-care providers pay rent to the REIT.¹ Given the rise of REITs in health care and their expanding global influence, policy makers should take a proactive stance towards regulating health-care REITs to disincentivise short-term profiteering and encourage long-term health-care investments that promote patient access and health-care quality.

REITs are investment trusts for which the primary holdings are real estate properties. REITs can be excluded from US federal income tax if more than 90% of their income is returned as dividends to shareholders.² Although REITs have historically invested in office buildings or hotels, there is a growing trend of REITs acquiring the real estate of hospitals as part of their income-generating portfolio. Health-care REIT transactions have evolved from a US phenomenon to an international one. The five largest publicly traded health-care REITs invested more than US \$65 billion across the USA (\$57 422 929 000), the UK (\$6 725 285 000; including more than

\$90 million in the National Health Service), Canada (\$5 969 890 000), and Europe (\$2 008 427 000).^{3–6} In an ideal situation, the cash infusion from the real estate sale to a REIT could allow hospitals to reinvest in technology, increase clinical staffing, or improve patient experiences. However, evidence does not suggest that REIT acquisition improves any of these aspects of clinical care or financially benefits acquired providers.^{3,7–9} Instead, REITs have increasingly been co-opted as part of a two-step strategy by private equity firms—strip hospital assets by selling the hospital real estate to a REIT and sell the resulting hospital operating company to yet another private equity firm so they can be rolled up with other health-care providers to increase shareholder profit.^{10,11}

The collapse of Steward Health Care shows the effects of this financial two-hit effect from private equity and REIT firms working in concert. In 2010, Cerberus Capital Management, a private equity firm, purchased the struggling Caritas Christi Health Care, the hospital network of the Archdiocese of Boston, to form Steward Health Care. Although the private equity owners of Steward assured regulators that more than \$400 million would be invested to improve the hospitals, they instead sold the nine hospitals in Massachusetts to



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