

Insights on global health reform discussions, trends and perspectives

15 June 2026

This is the fifth in a **series of *Insights papers*** summarising our understanding and analysis of global health reform discussions, trends and perspectives. Previous papers in this series are available [here](#).

We will continue to share regular updates and analyses around key issues and decisions shaping the future of global health.

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Our reflections and analysis

This section summarises our reflections on developments around reforms of the international system for health since the [April Insights paper](#), offering an analysis of the latest discussions. Descriptions of specific processes and events we have been following are provided in the main text of the paper.

In our previous *Insights papers*, we highlighted the risk of fragmented reform efforts and a leadership vacuum, and considered which constellations of actors may be best positioned to take the reform agenda forward.

Despite undergoing significant change itself, WHO was deemed the natural leader due to its convening power and central role within the international system for health. At the same time, more agile coalitions of the willing driven by the Global South, or the Global Majority, were widely seen as the most legitimate and effective approach.

These sentiments are reflected in the reform landscape today, with **two major reform initiatives underway: the Accra Reset**, led by President John Mahama of Ghana, and the **WHO-hosted reform process**, formally adopted by the 79th World Health Assembly.

The engine behind the Accra Reset is an 18-member High-Level Panel. Together with 4 co-chairs, **the Panel reports directly to President Mahama and a group of incumbent Heads of State. The Panel is expected to produce a set of bold reform proposals**, which these leaders will first champion at the United Nations General Assembly in September. **The WHO-hosted process will be spearheaded by a 25-member Joint Task Force, comprising predominantly Member States**, alongside global health initiatives and multilateral actors. In time for next year's Health Assembly, and after an interim report to relevant governing bodies in Winter 2026/27, the Task Force will finalise a suite of options and recommendations for reform, focusing on mandate coordination.

While there is ample curiosity around both processes, confidence in their ability to deliver change varies across the global health community. **Those closely engaged in reform discussions express concerns that the proposals may not be ambitious or transformative enough.** Advancing reforms that genuinely confront the status quo will necessitate successfully navigating the politics of global health and managing vested interests.

Discrepancies between rhetoric and reality, and between what is said in public fora compared to closed-door discussions, must be recognised. Reform conversations are far more palatable when kept at the level of systems and principles but become notably sensitive when they begin to unpick the underlying drivers of systemic dysfunction.

Actors can demonstrate honest commitment to reform by being the starting point of its implementation. In practice, this means institutions prioritising a more fit-for-purpose system over their self-preservation; countries in the Global North truly relinquishing some of their influence; and entities at the global level of health governance accepting the transfer of certain functions to regional bodies. While there may be broad support for the notion of regional and national self-sufficiency, its inevitable consequence, a redistribution of power, is likely less enticing.

Aiming merely at greater alignment of actors in the international system for health assumes that the continued existence of all actors is still justified. It also assumes that overlap and duplication of mandates are simply products of insufficient coordination, rather than symptoms of competition for resources and relevance. Therefore, **taking consolidation and institutional closure off the table from the outset noticeably dampens enthusiasm for global health reform.**

Reforms are both technically and politically challenging. Expectations of how the international system should be designed, and what it should deliver, are shaped in real time by geopolitical dynamics and emerging crises, not least the recent Ebola outbreak.

Agreement on overarching principles without clear operational definitions can quickly lose its practical value. Broad appeals to ‘country ownership’, ‘equitable partnerships’, and ‘sovereignty and subsidiarity’ risk becoming performative language and tokenistic expressions, regularly featured in global health speeches, but having limited impact on decision-making.

The gap between the issues affecting people’s health and the issues the international system for health is designed to tackle is widening. Global health reform must acknowledge that threats which once warranted concerted global action can now be managed locally, while there are new challenges that, by their very nature, cannot be tackled by individual countries alone.

Timing is an essential, though less discussed, piece of the puzzle. There is no on-and-off switch for sovereignty, and any transition will take years, with considerable variation between countries. This raises the question of how long it may take for high-level declarations to translate into tangible health improvements in the communities the international system is meant to serve. While self-sufficiency is a long-term vision, the steps to advance it can and must begin today.

Whether due to complacency, self-interest, or insistence on a flawless process, there is a risk that the ongoing sense of urgency will fade. Though the appetite for change remains strong, **this reform moment will be judged by whether it delivers meaningful outcomes, or becomes another collection of well-worded commitments.** With

significant leadership transitions approaching in 2027, including at the AU, WHO, Africa CDC, and The Global Fund, **now is the time to think, and act, boldly.**

A summary of ongoing reform discussions, trends and perspectives

Building on the [prior Insights papers](#), this section provides an overview of processes and voices shaping the current reform discourse and a synthesis of the key discussions. These are also presented in a [slide deck on global health reform](#).

Accra Reset

[Ghanian President John Dramani Mahama](#) hosted the Accra Reset [High-Level Dialogue](#) on Global Health Architecture on the sidelines of this year's World Health Assembly in Geneva. The [event gathered more than 250 participants](#), including heads of major multilateral institutions, Ministers of Health, and co-chairs of the [Accra Reset High-Level Panel](#). The Initiative was also featured and presented at several WHA side events, including [Devex Impact House](#) and [One Vision, One Future: Shaping the next chapter of health financing in Africa](#).

The High-Level Panel is currently developing recommendations aimed at advancing self-reliance in health, which could serve as a starting point for similar shifts across sectors, and in development cooperation more broadly. This work is unfolding under three workstreams: Innovation, production and access; Health financing; and Governance and institutional reform.

The Panel's mandate came directly from President Mahama, who requested a set of actionable reform recommendations that a group of engaged heads of state (*the Presidential Council*) can champion from the UN General Assembly this September, and into 2027 when Mahama assumes the chairmanship of the African Union. The recommendations must balance boldness with implementability, and Panel members are asked to be candid about why similar reform efforts have not been successful in the past.

An important milestone will be the full Panel convening in Senegal in mid-July, where recommendations from the three workstreams will be brought together and refined.

WHO-hosted reform process

At the [79th WHA](#), [Member States approved](#) the proposed [joint process](#) to support reforms of the global health architecture (GHA). The [process will be led by a 25-member Joint Task Force](#) comprising 14 WHO Member State representatives (two from each WHO region, alongside two co-chairs; one from a developing country and one from a developed country); five representatives from global health institutions (Gavi, Global Fund, CEPI, Unitaid and the Pandemic Fund); UN entities; the World Bank; and a regional health

organization. Member State nominations for participants in the Task Force are meant to be submitted to the Secretariat by July 31st.

The Task Force is expected to identify options to better align the mandates of GHA actors with key global health functions; strengthen coordination across different levels of health governance; and advance self-reliance while ensuring sustainable financing for global and regional health functions. These recommendations will be presented in a final report to the Health Assembly in 2027. Throughout the process, regular consultations with Member States will be held in Geneva.

While the decision to proceed with the joint process was broadly welcomed, the [scope of the process was scrutinised](#) by several Member States, philanthropies such as the Wellcome Trust, and civil society, criticising its lack of ambition. Particular concern centred on the statement that *‘The process will propose neither revisions to organizational mandates nor specific mergers or consolidations, which fall within the authority of the relevant governing bodies, and will not address disease- or intervention-specific approaches’*. This prompted some experts, including CGD’s Pete Baker, to [explicitly question the added value of the joint process](#).

Civil society groups also condemned their [exclusion from the Joint Task Force](#), warning that sidelining affected communities undermines accountability and leaves the architecture vulnerable to commercially driven interests.

In his [keynote speech at the WHA79](#), President Mahama emphasised that the [joint process should not shy away from considering mandate changes and institutional mergers](#). He warned that *‘If we launch a process of reform that is prohibited from recommending actual reform, we are merely performing a ritual. We cannot prioritize institutional comfort over human survival’*.

Although the WHO-hosted process and Accra Reset are expected to engage closely to ensure complementarity, they will remain distinct initiatives. Accra Reset is operating on a faster timeline and may provide useful inputs, but its purpose extends beyond informing the WHO-hosted process.

Notably, neither initiative directly addresses internal change of WHO. Therefore, there is a risk that’s WHO’s own reform needs could fall between the cracks of broader discussions on global health reform.

Future of WHO

Writing for [The Lancet](#), Anders Nordström, John Nkengasong, Peter Piot, Magda Robalo Correia e Silvae, Ala Alwan, Ethel L Maciel, Ren Minghui, and Michel Kazatchkine argue

that WHO risks becoming increasingly irrelevant unless it refocuses on and strengthens three core functions: norm and standard setting; surveillance and cross-border threat management; and convening. They propose six reforms spanning governance, staffing, and financing, and refer to the forthcoming Director-General election as a critical opportunity to debate WHO's future direction.

[In a piece for the BMJ](#), Martin McKee and Kent Buse also see the DG election as consequential in many ways. They suggest that whoever takes office will inherit a fractured geopolitical landscape and will have to find diplomatic means to defend WHO's neutrality in the face of rising political pressures.

Impressions from the World Health Assembly

Besides being featured on the World Health Assembly's formal agenda, global health reform was a prominent topic in several convenings and conversations on the margins of the WHA79. The Partnership for International Politics and Diplomacy for Health [hosted a side event](#) bringing together esteemed global health leaders who openly reflected on *What's at stake and what comes next for global health reform*. Participants warned against 'reformitis'; a tendency to engage in extensive discussions about reform without taking meaningful action. Institutional self-preservation was highlighted as a central obstacle, and a deep-rooted trust deficit among key stakeholders described as a major 'elephant in the room' in reform debates.

The Lancet Editor-in-Chief Richard Horton subsequently published [a comment summarising his frank impressions](#) from the event and the broader atmosphere in Geneva. Most pointedly, he called out 'epic dishonesty', and leaders who make commitments they have no intention of keeping. Horton concluded that before any meaningful reform can take place, the global health community must first stop deceiving itself and others. Without truth, he noted, there is nothing to build on. [Ebere Okereke complemented these reflections](#), stressing that truth should not only be articulated, but also acted upon.

Expert comments and research insights

With the World Health Assembly prompting extensive thinking and exchanges around the future of global health, recent weeks have generated a variety of publications relevant to global health reform.

Seed Global Health, Harvard T.H. Chan School of Public Health and the Ugandan Ministry of Health conducted [an analysis of global health reform landscape](#), comparing domains, mechanisms, thematic areas, governance and financing between what the authors refer to as '11 key initiatives'. Vanessa Kerry and Jane Ruth Aceng published an [accompanying argument in Foreign Policy](#). Both pieces received notable traction in Geneva, and sparked a conversation around what truly constitutes a reform initiative, and which efforts are better described as analytical works or policies influencing the reform discourse.

The Multilateral Organisation Performance Assessment Network (MOPAN) published [a study mapping the mandates](#) of nine major multilateral organizations against possible priority functions of a reformed global health architecture. The study finds that mandates expand but seldom contract, largely because of donor expectations and financial incentives. Therefore, narrowing mandates is necessary but insufficient, and it must be accompanied by meaningful changes to the underlying financing, accountability, and governance arrangements that drove mandate expansion in the first place. MOPAN plans to publish two additional outputs to support global health reform discussions; an assessment of comparative advantage across priority global health functions (September 2026); and an outline of reform pathways (December 2026).

In mid-May, Devex outlined [some of the 'hardest truths'](#) the global health community is struggling to accept, according to 11 leaders in the field. Among these were the recognition that ODA will no longer be the primary source of health financing; that the previous aid model cannot simply be revived; that institutions are often motivated by self-preservation; that issues which received the bulk of international funding decades ago may no longer warrant the same level of prioritisation; and that being too sentimental about the existing global health architecture risks doing more harm than good.

In an [article for the Telegraph](#), Sania Nishtar argued that a reformed and streamlined WHO should occupy the central position in the international system for health. In her view, remaining institutions should either focus on uniquely global functions or be consolidated or closed. Similarly, Gates Foundation CEO [Mark Suzman wrote in Foreign Affairs](#) that global health institutions should gradually transfer their functions to countries, narrow their objectives and plan for obsolescence.

Commentaries for [WHS Perspectives](#) and [Chatham House](#) by Ilona Kickbusch reiterated that debates about global health reform inevitably boil down to debates about power, while a [satirical text](#) entitled 'How (not) to design the future of global health architecture' by Jirair Ratevosian and colleagues pointed out that some of the current approaches to reform may deliver superficial changes, but ultimately perpetuate the structural status quo.

In an [Opinion for Devex](#), Daniel Thornton presented insights from private-sector mergers and acquisitions of relevance to global health reform discussions, underscoring the potential consequences of dragging out and delaying institutional consolidation.

Other relevant publications and developments

The Wellcome Trust produced [a report from its high-level global dialogue on global health reform](#), held in Bangkok in April 2026. Building on five regional dialogues convened in 2025, the report reaffirms widespread calls for a decentralised, country-driven global health system, anchored at the regional level and backed by a leaner global architecture,

with sovereignty signifying genuine control over priorities and financing. Consolidation of global health institutions, including mergers and sunseting of institutions, was identified as necessary, while the WHO-hosted process and the Accra Reset were deemed the key vehicles for taking reforms forward.

Many of the core principles underpinning current reform discussions were also championed at [The World Health Summit Regional Meeting](#), held in Nairobi from 27-29 April under the theme ‘*Reimagining Africa’s Health Systems: Innovation, Integration and Interdependence*’. The meeting brought together more than 3,000 participants from over 80 countries, and featured numerous interventions from African leaders, including Kenyan president William Ruto, expressing determination to assume full responsibility over health in their respective countries.

[The European Commission](#) adopted its Global Health Resilience Initiative in May 2026, putting forward five key priority areas: Promoting a more effective and less fragmented global health architecture; Supporting resilient and country-led health systems; Reinforcing international-level prevention, preparedness and response to global health threats; Diversifying global supply chains and manufacturing of key health products; and Bolstering societal resilience against health dis- and misinformation. As [Health Policy Watch reports](#), the Initiative explicitly acknowledges the need for a more coherent international system for health, with Commissioner Sikela noting ‘*there are too many players, too many overlapping mandates*’.

About us

The Partnership for International Politics and Diplomacy for Health is a collaboration between the Stockholm School of Economics and Karolinska Institutet. Our work consists of four complementary and mutually reinforcing work streams: an Executive Program for future health leaders, the Health Diplomacy Institutional Network, focused Research efforts, and Policy engagements.

Our policy work seeks to contribute to the international dialogue on what a reformed international ecosystem for global health could look like. We call this workstream ***Paradigm Shifts for Global Health - Supporting Diplomacy and Policy Pathways***. This is not a standalone initiative or process, but a means through which we engage as both originators and conveyors of ideas that could potentially assist in paving the way for a reformed international ecosystem for health.

Read more here: <https://globalhealthdiplomacy.se/policy-engagements>