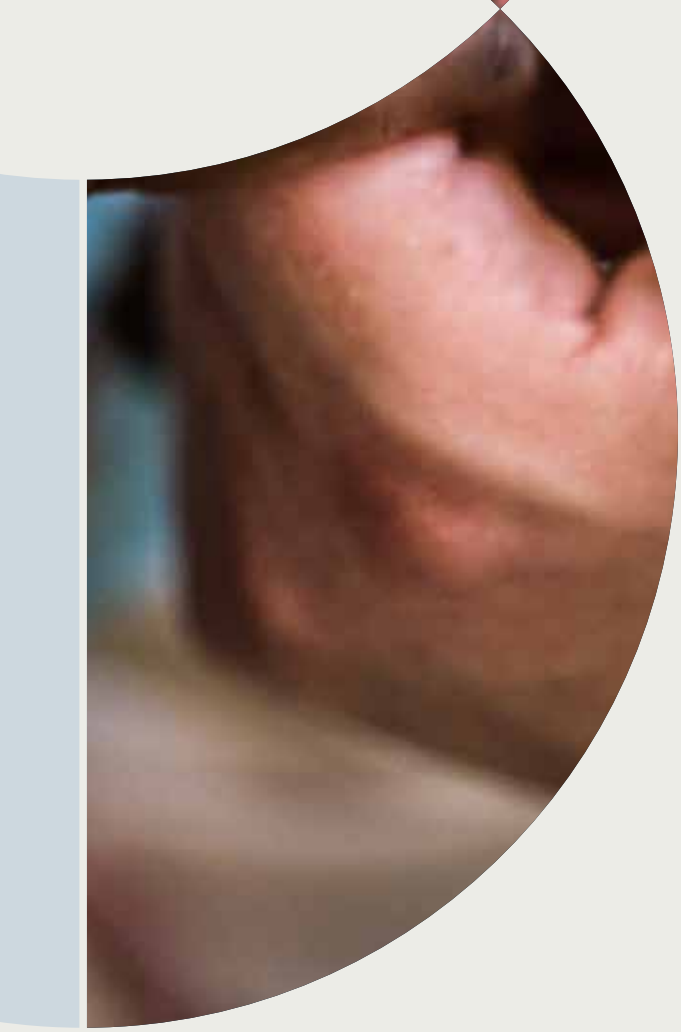
Published November 2026





# MOPAN INSIGHTS

## Comparative Advantage in the Multilateral Health Ecosystem

Output 3: Reform Pathways

MOPAN



This document is published under the responsibility of the Multilateral Performance Network (MOPAN). MOPAN is an independent body that is governed by a Steering Committee composed of representatives of all its member countries and served by a permanent Secretariat. The Secretariat is hosted at the organisation for Economic Co-operation and Development (OECD) and is bound by its administrative rules and procedures. It is independent in terms of financing and the content and implementation of its work programme.

This document, as well as any data and any map included herein, are without prejudice to the status of or sovereignty over any territory, to the delimitation of international frontiers and boundaries and to the name of any territory, city or area.

Please cite this publication as:

MOPAN INSIGHTS (2026), *Comparative Advantage in the Multilateral Health Ecosystem - Output 3: Reform Pathways*, MOPAN Publishing, Paris,

© MOPAN 2026

# Acknowledgements

The study was prepared under the overall strategic guidance of Suzanne Steensen (Head of the MOPAN Secretariat), the supervision of Patrick Saez (MOPAN Senior Policy Advisor and Head of Unit for Insights), and the leadership and oversight of Jo Scott-Nicholls and Anna Seymour (MOPAN Senior Health Lead).

Allison Beattie (Research Team Lead, Agulhas Applied Knowledge), with Giulia di Porcia e Brugnera (Senior Analyst and Evaluator), conducted the data collection and analysis of the multilateral organisations included in this study. Carole Presern and Clare Dickinson provided quality assurance and valuable comments to this publication. Camille Hewitt co-ordinated the editing, design and layout process and Bradyen Friesden provided editing support.

This study would not have been possible without the close engagement and contributions of many senior officials and technical staff from the multilateral organisations. In alphabetical order: Gavi, the Vaccine Alliance; Global Financing Facility for Women, Children and Adolescents; Global Fund to Fight AIDS, Tuberculosis and Malaria; Pandemic Fund: United Nations Population Fund; United Nations Children's Fund; Unitaid; World Health Organization; and the World Bank.

We extend our sincere thanks to the members of the Advisory Group. In the group, Belgium, Canada, France, Germany, Norway, Sweden, and the United Kingdom championed the work on behalf of MOPAN members. They were represented by Koen Van Acoleyen, Minister Counselor at Permanent Representation of Belgium to the UN in Geneva; Anar Mamdani, Director of Global Health Policy and Strategy at Global Affairs Canada (supported by Ayah Nayfeh); Anne-Claire Amprou, Ambassador for Global Health of France and Chair of the Executive Board of Unitaid (supported by Amélie Schmitt); Hariet Ludwig, Senior Policy Advisor on Global Health and Sustainable Development, German Federal Ministry for Economic Cooperation and Development (BMZ); Marit Viktoria Pettersen, Senior Adviser, Norwegian Ministry of Foreign Affairs; Karin Tegmark Wisell, Ambassador for Global Health of Sweden (supported by Anna Halén and Lisa Kronestedt); Ella Carpenter, Head of Global Health Systems, Commonwealth and Development Office, United Kingdom.

Acting in their personal capacity: Walid Ammar, former Minister of Health, Lebanon; Nana Oye Bampoe, Deputy Chief of Staff for Administration, Ghana; Clare Battle, Policy Lead, Wellcome Trust; Cécile Billaux, Head of Unit, Directorate General for International Partnerships, European Commission; Sue Graves, Deputy Director, Gates Foundation; Hugo López-Gatell Ramírez, former Deputy Minister of Health, Mexico; Gerald Manthalu, Head of Division, PFM and Lusaka Agenda, Africa Centre for Disease Control and Prevention (Africa CDC); Lwazi Manzi, Head of Secretariat Global Leaders Network for Women, Children and Adolescent Health, South Africa; Belinda Nimako, Director, Policy Planning, Monitoring and Evaluation, Accra Reset, Ghana; Cedric Nininahazwe, Director of Global Advocacy, Positioning and Partnerships, GNP+; and Suwit Wibulpolprasert, Vice Chair, International Health Policy Program, Thailand.

Finally, MOPAN is grateful to all Steering Committee representatives and member countries for their financial contributions, which made this study possible.

# Table of contents

Acknowledgements ..... 3
Abbreviations and acronyms ..... 6
Glossary ..... 7

**Executive summary ..... 9**
**Introduction ..... 12**
**From evidence to reform ..... 15**
**Ten Reform Objectives ..... 21**

Implication: Centre the future global health architecture around countries ..... 23
1. Consolidated external financing for health systems in each country ..... 23
2. One country compact, binding on all partners ..... 24
3. A defined, complementary role for external support ..... 25
Implication: Shift financing incentives and behaviours of external partners ..... 26
4. Longer financing horizons for national institutions ..... 26
5. Harmonised co-financing and transition pathway ..... 27
6. Integrated market shaping across essential products ..... 28
7. A standing arrangement to oversee roles and mandates ..... 29
8. System-wide oversight of funding flows ..... 30
9. Joint financing for shared global functions ..... 31
10. Shared detection, alert and response ..... 32

**Taking the reforms forward ..... 33**
**Annexes ..... 41**

Annex A. Taking reform forward: worked examples ..... 42
Annex B. Reform complexity and benefit scoring tool ..... 47
Annex C. The flow from evidence to Reform Objectives ..... 49

# Boxes, Tables & Figures

Box 1. Ways of working that can start now, without wider reform ..... 22

Table 5. Taking the Reform Objectives forward: feasibility, cost of change and levers ..... 36
Table 6. What the Reform Objectives suggest for each organisation ..... 37
Table A A.1. Consolidated external financing for health systems in each country ..... 42
Table A A.2. Harmonised co-financing and transition pathway ..... 43
Table A A.3. Integrated market shaping across essential products ..... 44
Table A A.4. Shared detection, alert and response ..... 45
Table A A.5. The four decision lenses and the Reform Objectives ..... 46
Table A B.1. Scoring complexity ..... 47

Figure 1. Implications setting the direction for ten Reform Objectives ..... 11
Figure 2. How MOPAN's proposed Reform Objectives align with current reform initiatives ..... 14
Figure 3. Roles of the nine organisations across the six functions ..... 17
Figure 4. Principles, Implications and Decision Lenses ..... 19
Figure 5. The four decision lenses ..... 20
Figure 6. Who can make the reforms happen ..... 34
Figure 7. Complexity and benefit of the Reform Objectives ..... 35

# Abbreviations and acronyms

| | |
|---|---|
| CEPI | Coalition for Epidemic Preparedness Innovations |
| DAH | Development assistance for health |
| EU | European Union |
| F1–F6 | The six global health functions used in the study (see Glossary) |
| Gavi | Gavi, the Vaccine Alliance |
| GFF | Global Financing Facility for Women, Children and Adolescents |
| GHA | Global health architecture |
| GHI | Global Health Initiatives |
| Global Fund | The Global Fund to Fight AIDS, Tuberculosis and Malaria |
| HLP | Accra Reset High-Level Panel on the Reform of the Global Health Architecture and Governance |
| IHP+ | International Health Partnership |
| MOPAN | Multilateral Organisation Performance Assessment Network |
| Pandemic Fund | Financial Intermediary Fund for Pandemic Prevention, Preparedness and Response |
| SDG | Sustainable Development Goal |
| UN | United Nations |
| UN80 | United Nations at 80 reform initiative |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| WHA | World Health Assembly |
| WHO | World Health Organization |
| WS1–WS3 | The three workstreams of the WHO-hosted Joint Process |

# Glossary

| | |
|---|---|
| Assessed contributions | Mandatory financial contributions from member states to an intergovernmental organisation, set according to an agreed scale. Contrasted with voluntary contributions. |
| Benefit score | In the tool proposed in Output 3, a score from 0 to 10 for the likely benefit of a Reform Objective: up to 5 for benefit to countries and up to 5 for benefit to the system. |
| Collective capability | What the nine organisations can deliver together across the six global health functions. |
| Co-financing | A requirement that a country government pays an agreed and usually rising share of the cost of a programme supported by an external funder. |
| Comparative advantage | Which organisation is relatively best placed to perform a specified function, or part of one, compared with the other organisations in the study. It is a relational concept, not an assessment of performance in isolation. |
| Complexity score | In the tool proposed in Output 3, a score from 0 to 14 for how hard a Reform Objective would be to achieve, based on how many organisations and boards must agree and how much must change in mandates, financing flows, organisation design and the role of countries. |
| Configuration | How capabilities are arranged across the organisations: who does what, how each contribution is financed, and how contributions connect across organisations and across global, regional and country levels. |
| Country compact | An agreement, chaired by the government, that sets out one national plan and budget that all external partners follow, with commitments that bind funders as well as the government. |
| Decision lenses | Four outcomes that are at stake in every reform choice: equity; fragile and conflict-affected settings; the changing burden of disease; and subsidiarity and the role of regional institutions. The weight given to each shapes how a reform is designed, how funds are used and which risks are acceptable. Output 2 refers to them as cross-cutting issues. |
| Development assistance for health (DAH) | Financial and in-kind resources transferred to low- and middle-income countries to improve health. DAH is related to, but distinct from, the global health architecture, which concerns all countries. |
| Degree of system change | The three-step scale used in this report to describe options for each Reform Objective: align (organisations keep their own arrangements but bring them into line with each other and with national systems), integrate (shared arrangements replace separate ones) and reshape (roles, funding or mandates are reallocated across the system). |
| Earmarked funding | Funding that a donor provides for a specific purpose, place or project, which limits how the receiving organisation can use it. |
| Fitness for purpose | Whether the collective capability of the organisations, as configured, meets the requirements of the six global health functions. |
| Global health architecture | The combination of actors, frameworks and processes that guide, coordinate, finance and carry out efforts to improve and protect health globally. It concerns all countries. |

| | |
|---|---|
| Global health functions | The six priority functions used throughout the study: setting norms and standards (F1); strengthening country health systems (F2); developing and delivering health products (F3); tracking population health, detecting health threats and raising the alarm (F4); responding to emergencies (F5); and stewardship, meaning coordinating the global health system and holding it accountable (F6). |
| Global public goods | Goods whose benefits are available to every country at once and cannot be withheld from any, so that no single country has an incentive to pay their full cost. In health they include norms and standards, agreed global statistics, prequalification and international alerts. Global public goods describe the nature of the benefits; functions describe what needs to be done; development assistance for health is one way of financing both (Output 2). |
| Implication | One of four directions for reform drawn from the conclusions of Output 2. Each Implication responds to a problem the evidence identifies. |
| Market shaping | Actions that change the structure, prices or incentives of markets for health products to improve access, such as pooling demand, negotiating prices, making advance commitments to buy, and reducing the risks of entering a market. |
| Mutual recognition of assurance and audit | An arrangement under which an assessment or audit of a country system accepted by one organisation is also accepted by the others, so that governments face fewer repeated assessments. |
| Prequalification | WHO's assessment of the quality, safety and effectiveness of medicines, vaccines, diagnostics and other health products, on which most international procurement depends. |
| Reform Objective | An area for reform where the evidence points clearly to the need for change and which the organisations must address together. Output 3 sets out ten. Each can be achieved in several ways, and Output 3 does not prescribe the route or the sequence. |
| Stewardship | Coordinating the global health system and holding it accountable, including deciding roles, mandates and financing across organisations (function F6). |
| Subsidiarity | The principle that each function should be carried out at the level closest to countries (country, regional or global) at which it can be done efficiently and effectively. |
| Transition | The planned shift from external financing of a programme or service to domestic financing and national management. |
| WHO-hosted Joint Process | The process on reform of the global health architecture established by the World Health Assembly in May 2026, organised in three workstreams: functions, mandates and capacities; coordination and decision-making; and financing. |



# Executive summary

This report completes MOPAN's three-part study of the global health architecture. It turns the evidence of Output 1 on mandates and Output 2 on comparative advantage into ten Reform Objectives. It identifies what should change, not a single route or sequence: those are political choices for governments, boards and funders.

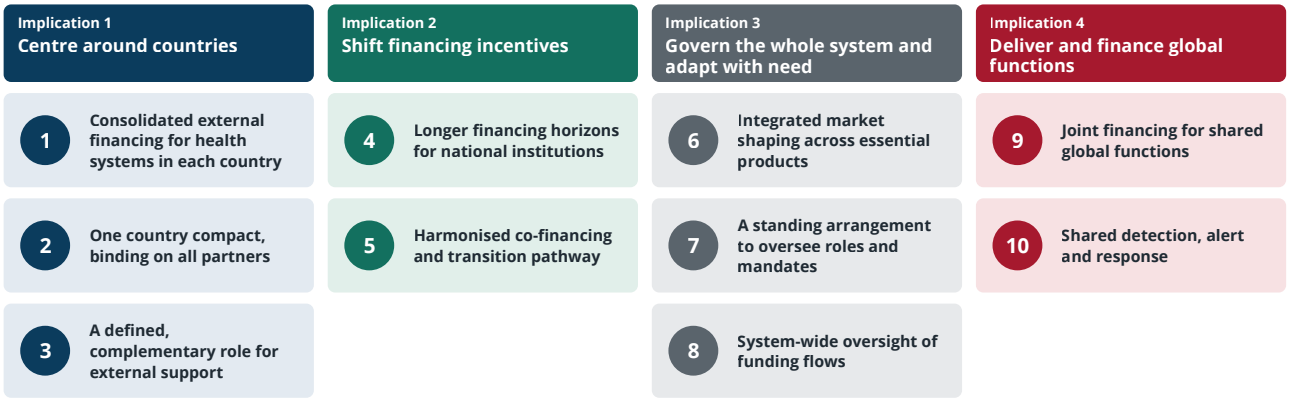
A future global health architecture must respond to today's geopolitical realities, evolving health needs, and changing financing landscape. With development assistance for health projected to decline by 19-33% from 2023 levels, countries are carrying more of the cost. MOPAN's analysis finds that the nine organisations collectively cover much of what the six future global health functions require. The central challenge is in addressing how their capabilities are configured, financed and governed; how the burdens imposed by the current architecture on countries can be reduced; and how gaps in shared functions and system-wide stewardship can be addressed.

Two principles apply to every reform: build on comparative advantage, so that each organisation concentrates on what its mandate and design equip it to do and steps back where others are better placed; and protect what cannot readily be rebuilt, such as global standards, prequalification, emergency authority and global health data. The evidence leads to four Implications:

1. **Centre the future global health architecture around countries.** External support for country health systems is not a coherent offer and can substitute for national systems; countries spend scarce capability managing separate external processes.
2. **Shift financing incentives and behaviours of external partners.** Financing rewards results that organisations and funders can attribute to themselves, often over short cycles and around externally-driven priorities; and each funder times transition from its support on its own terms.
3. **Govern the global health system as a whole and adapt it as needs change.** No organisation can steward the system as a whole or direct its independently governed peers; and roles, mandates and financing have not been designed collectively or adapted coherently to meet changes in future burden of disease and climate-related health risk.
4. **Deliver and finance global functions and global public goods fairly and predictably.** Norms and standards, prequalification, data and alerts are paid for by a few donors, cycle by cycle and mostly earmarked.

These Implications set the direction for ten Reform Objectives as follows:

*Figure 1. Implications setting the direction for ten Reform Objectives*




The ten Reform Objectives focus on strengthening how organisations work together. For each objective, the report outlines multiple pathways for progress, including strengthening alignment of existing arrangements, greater integration and reshaping of roles, funding mechanisms or mandates. Some actions can be implemented immediately without formal reform, such as clearly defining shared responsibilities and ensuring coherent government positions across governing boards. Others are complex requiring more structural change and multiple levers to make them happen but delivering greater benefit.

Four decision lenses can help assess reform design and make trade-offs explicit: equity; fragile and conflict-affected settings; the changing burden of disease; and subsidiarity. As external financing declines, support will need to be tailored to countries' income levels, capacities and vulnerabilities, with low-income and fragile contexts likely to require the greatest assistance. Reform is possible across multiple fronts; the choices about pace, ambition and risk now rest with decision-makers.

# Introduction



***Image credit:*** Anirudh | Unsplash

## Why reform and why now

The demands on the global health system are changing faster than the architecture that serves it. Development assistance for health is projected to fall by 19–33% from 2023 levels,[1] and geopolitical shifts are changing which priorities are funded and through which channels. Domestic resources now carry more of the cost in most countries, regional institutions are taking on functions once held globally, and non-communicable diseases, mental health and ageing account for a growing share of need. Reforming the architecture is therefore a political task as much as a technical one: governments, boards and funders must decide together who does what, who decides, and who pays.

## MOPAN's three-part study

MOPAN's study looks at nine multilateral organisations (WHO, UNICEF, UNFPA, the World Bank Group (Health and Nutrition Department),[2] the Global Financing Facility (GFF), the Global Fund to Fight AIDS, Tuberculosis and Malaria, Gavi, the Vaccine Alliance, the Pandemic Fund and Unitaid) against six proposed future functions of the global health system.[3]

Output 1 mapped organisation mandates against these functions. Output 2 assessed where comparative advantage lies and whether the nine organisations, as configured, are fit for purpose. Output 3 turns that evidence into Reform Objectives. Reform points towards two shifts: in each country, the shift from external to domestic financing in pursuit of universal health coverage, protecting people and services along the way; and, globally, the wider shift in how the architecture is financed, governed and organised as needs, resources and geopolitics change.

In this report, Chapter 2 sets out what the evidence shows, why financing matters, and the principles, implications and decision lenses that follow. Chapter 3 sets out ten Reform Objectives under the four Implications and shows what each would change and what it implies for the nine organisations. Chapter 4 turns to pathways, showing the initial stages of how Reform Objectives could be taken forward: who holds the levers, benefit and complexity, feasibility and cost, and where to start. Annexes provide additional detail and Annex C traces each Reform Objective back to its evidence.

1 OECD (2025), 'Cuts in official development assistance: OECD projections for 2025 and the near term', OECD Policy Briefs, No. 26, OECD Publishing, Paris, https://doi.org/10.1787/8c530629-en.
2 Regional and other multilateral development banks were outside the scope of this study, but they have a critical role in health financing alongside the World Bank. Where this report refers to the World Bank, other development banks could in many cases play the same role.
3 The six functions are: F1 setting norms and standards; F2 strengthening country health systems; F3 developing and delivering health products; F4 tracking population health, detecting and raising the alarm on health threats; F5 responding to emergencies; and F6 stewardship: coordinating the global health system and holding it accountable. They were adopted in Output 1 from an early iteration developed through the WHO-hosted Joint Process. They have not yet been formally agreed in that process.

## How the MOPAN study relates to current reform initiatives

MOPAN's work is one of several contributions to wider reform dialogues, including the WHO-hosted Joint Process on Global Health Architecture Reform. The proposed Reform Objectives of this report are compared with seven other proposals and processes, including the final report of the Accra Reset High-Level Panel,[4] the Lusaka Agenda[5] and UN80.[6]

The degree of agreement is high, adding support to reforms proposed by this report (Figure 2). Agreement is strongest on joint financing for shared global functions, on a country compact that binds partners as well as governments, and on building agreed transition pathways. Where the processes differ, it is mostly on the proposed route and pace rather than on objectives. Some processes go further and propose mergers or closures. This report does not endorse specific mergers, but its evidence is clear that the duplication created by separate funding mechanisms, each with its own processes in the same country, is one of the central costs of the current architecture.

*Figure 2. How MOPAN's proposed Reform Objectives align with current reform initiatives*

| | Reform objective | Accra Reset HLP† | Nature Medicine and Wellcome | EU and like-minded donors | Future of health financing* | Lusaka Agenda | UN80 | Pate, Kaberuka and Piot |
|---|---|---|---|---|---|---|---|---|
| 1 | Consolidated external financing for health systems | ●●● | ●●● | ● | ●● | ● | ● | ●● |
| 2 | One country compact, binding on all partners | ●●● | ●●● | ●●● | ●● | ●●● | ● | ● |
| 3 | A defined, complementary role for external support | ●● | ●●● | ● | ●●● | ● | | ● |
| 4 | Longer financing horizons for national institutions | ● | ●●● | ● | ●● | ● | | |
| 5 | Harmonised co-financing and transition pathway | ●●● | ●● | ●●● | ●●● | ●●● | | ● |
| 6 | Integrated market shaping across essential products | ●● | ●●● | ● | ●● | ● | ● | ● |
| 7 | A standing arrangement to oversee roles and mandates | ●● | ●● | ●● | ●● | ● | ●● | ●● |
| 8 | System-wide oversight of funding flows | ●● | ●● | ●● | ● | ●● | | ●● |
| 9 | Joint financing for shared global functions | ●●● | ●●● | ●●● | ●●● | | | ●●● |
| 10 | Shared detection, alert and response | ●● | ●● | ●●● | ●● | | ● | ● |

●●● Same proposal ●● Same aim, different route ● Partially addressed Not addressed

*† Final report, September 2026. The HLP, Pate and colleagues, and the Nature Medicine Comment share authors and are not fully independent.*
** Stockholm School of Economics and Karolinska Institutet, September 2026. The WHO Joint Process is not rated: it has not yet published recommendations. Where two earlier objectives were merged (1 and 2), the higher rating is shown.*

4 Accra Reset High-Level Panel on the Reform of the Global Health Architecture and Governance (2026), Accra Reset – Full Circle: A Sovereign Future for Health, September 2026.
5 Future of Global Health Initiatives (2023), The Lusaka Agenda: Conclusions of the Future of Global Health Initiatives Process, December 2023.
6 United Nations, UN80 Initiative, launched by the Secretary-General in March 2025 to review the efficiency, mandates and structure of the UN system.



# From evidence to reform

## Summary of MOPAN's evidence

**Mandates** overlap across all six functions (F1-6). Mandates have grown over time, no governing body has ever formally reduced one, and no individual body has the authority to ask whether a function is already performed elsewhere. Earmarked funding, more than formal mandates, shapes what organisations do in practice.

**Comparative advantage** is differentiated across the nine organisations and bound by mandate, design and authority. Distinctive strengths produce greatest collective value where roles are agreed in writing and separately financed, as for F3: health products. It is weakest where results are shared, hard to attribute or hard to show, such as prevention, global data and coordination. The nine organisations were never designed to work as one system.

**Financing** - who pays, on what terms and for how long - is the strongest single explanation for how the architecture behaves. It shapes which capabilities develop in practice. Most funding to the UN organisations in the study is earmarked,[7] and most external financing reaches countries outside national budgets through separate processes. Funding rewards results that a single funder can attribute to itself, over short cycles and by disease or theme. Coordination, shared results and institutions that last beyond a programme are hard to attribute, and so are weakly rewarded. The costs fall on countries, which do the coordinating, and on the shared functions every country relies on, which are the least protected when funding falls.

**Functions,** and sub-functions,[8] sit at different levels, and each part should be carried out where it works best. Norms and standards and stewardship are largely global, strengthening country health systems is almost entirely national (the global role is time-limited financing and technical assistance rather than delivery), and health products, detection and emergency response are shared across global, regional and national levels[9]. As regional and national institutions grow stronger, more of this work can move closer to countries. Taken together, the nine organisations cover much of what the six functions require, but unevenly. The problem is not about missing organisations or capabilities, but rather how existing capabilities are configured, financed and governed. Figure 3 shows the pattern of roles, where the sub-functions sit and what the evidence shows.

7 Earmarking shares differ by source and measure. On OECD data on disbursements (mean 2022–23), 64% of funding to WHO, 85% to UNICEF and 66% to UNFPA was earmarked (Output 1, Figure 1); this report uses these figures. Measures based on organisations' own reporting of voluntary contributions give higher shares: Output 2 reports that more than 80% of WHO's income is earmarked. Member states have agreed a path to assessed contributions covering 50% of WHO's base budget by 2030–31.

8 See functions definitions and 51 sub-functions in Output 2: Annex A and Annex D. Annex D lays out how the functions could be decentralised to regional and country levels.

9 Output 2 distinguished three related but distinct concepts. Global health functions describe what needs to be done. Global public goods describe the nature and reach of benefits: available to every country at once, cannot be withheld from any, and so no single country has an incentive to pay their full cost. Development assistance for health (DAH) is a financing modality, one source of funding for both global and country-level activities. Most functions have a global public good part (for example norms and guidelines, prequalification, international alerts and global statistics) and a part that benefits a particular country (for example building its surveillance, laboratories and data systems) which are the least securely financed. Much of the country-level part is paid for through DAH (Output 2, Table 2 and Annex I).

*Figure 3. Roles of the nine organisations across the six functions*

| Function | WHO | UNICEF | UNFPA | World Bank | GFF | Global Fund | Gavi | Pandemic Fund | Unitaid | Where its sub-functions sit | What the evidence shows |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **F1 Set norms and standards** | L | C | L | C | | | | | E | Largely global: most norms work only if there is one version. Day-to-day regulatory review is moving to regional bodies. | WHO is the clear anchor. The weakness lies in implementation and secure financing, and the GHIs' own guidance multiplies the rules countries must follow. |
| **F2 Strengthen country health systems** | C | C | C | E | E | E | E | E | | Almost entirely national: eight of ten sub-functions. The global role is narrow: aligning external financing and setting rules on health-worker recruitment. | Collective capability is substantial, but it does not combine into long-term institutional support. Duplication is greatest here. |
| **F3 Develop and deliver health products** | L | L | L | E | E | L | L | | L | The most evenly spread: product development is primarily global; regulatory review and manufacturing are best-situated at regional; procurement is mixed. | The most strongly-configured function where roles are written down and financed. Gaps lie in new product areas, overlapping buyers and links to regional institutions. |
| **F4 Detect and raise the alarm** | L | C | C | E | C | E | E | E | E | A limited global layer (early warning, global estimates, data standards) over national and regional surveillance. | WHO's alert role is strong, but data streams and investments are not integrated, and surveillance is often funded country-by-country as elective development assistance for health. |
| **F5 Respond to emergencies** | L | L | L | E | E | E | E | E | E | National by default, with a global capability needed for cross-border outbreaks and where no government can or will act. | More actors since COVID-19 but no clearer coordination; a standing capability for crises without a consenting government is underdeveloped. |
| **F6 Stewardship** | L/C | | | E | C | C | C | C | | Largely global: coordinating financing, mutual accountability and reform need a vantage point above individual organisations. | No organisation or arrangement can steward the architecture as a whole; mandates are never reduced and funding flows are not mapped. |

Lead: holds or drives the function  Contributor: does part of the work itself  Enabler: finances, hosts or sets conditions for others

**Limited:** minimal or no role The trellis fill indicates that WHO leads on aspects of F6 but not all

***Source:*** MOPAN Output 2. Annex G summarises the strengths and gaps for each function.

**Gaps:** Across the functions, a number of gaps exist. External assistance for country health systems does not combine into a coherent offer or long-term institutional support. No organisation or arrangement is positioned to steward the global health architecture as a whole - each has its own governing body, funders and results framework, and no organisation has the authority to direct its independently governed peers. Detection of threats has a clear lead in WHO, but separate data streams and investments are not integrated. In emergencies, the UN agencies deliver and the GHIs fund and the World Bank finance, with uneven access and continuity in the most fragile settings.

**Duplication:** Where several organisations work in the same space without agreed roles, the same work is done more than once.[10] In a single country, some ministries manage eight or more funders on different cycles. The clearest case is financing for country health systems: up to five global funds and agencies may each run their own scheme in a country, with separate applications, appraisal, assurance, audit, co-financing, reporting and transition, often for similar purposes.

**Collective capability is slow to adapt** to changing needs such as non-communicable diseases, mental health conditions and ageing. Non-communicable diseases now cause around three quarters of deaths worldwide but attract less than 2% of development assistance for health.[11] Shifting this requires boards and funders to authorise and finance change beyond established priorities, invest in strengthening primary health care systems, and expand market shaping to a broader range of products.

**Equity and fragile settings**: The nine organisations are better configured to direct resources towards poorer and higher-burden countries than to support equitable allocation and access within them. In fragile and conflict-affected settings, results follow what still functions, and the transition of support towards national leadership is not consistently planned.

## How the evidence points to Reform Objectives

The evidence, findings and conclusions from Outputs 1 and 2 led to the design of Principles and Implications for reform (Figure 4). Reform Objectives have been identified under each Implication, focusing on areas where the evidence was both substantial and where changes require collective action by organisations together. They identify *areas* for reform rather than prescribing how they should be achieved. Some Reform Objectives restate long-standing aid-effectiveness commitments, from the Paris Declaration (2005) through Accra (2008), Busan (2011) and the Global Partnership for Effective Development Co-operation to the Lusaka Agenda.[12] What the evidence adds is an explanation of why these commitments have not been realised.

**Assumptions**: the Reform Objectives rest on some key assumptions; That external financing for health continues to decrease, and that low-income and fragile contexts are likely to need more external funding relative to middle-income countries which will rely increasingly on domestic resources, in line with commitments such as the Abuja Declaration. The Reform Objectives also assume that governments are willing and able to lead, funders are willing to accept results that are shared rather than attributable to them alone, and broad participation by member states and funders in the World Health Assembly and governing boards.

10 Output 2, Findings 5 and 8, and Annex D on the distribution of functions.
11 Output 2, Finding 9, drawing on WHO and on the IHME Global Burden of Disease and development assistance for health databases. More recent IHME estimates show that development assistance for non-communicable diseases fell by approximately a third between 2020 and 2023 (IHME, Financing Global Health 2023).
12 Paris Declaration on Aid Effectiveness (2005); Accra Agenda for Action (2008); Busan Partnership for Effective Development Co-operation (2011); the Global Partnership for Effective Development Co-operation (established in 2012); and the Lusaka Agenda (2023).

## Organising framework

Two principles apply to every reform (Figure 4) following findings on where comparative advantage comes from and where it is least protected. Four implications set the direction for reform.

***Figure 4. Principles, Implications and Decision Lenses***

| | | |
|---|---|---|
| Two principles apply to every reform | **Build on comparative advantage**: Each organisation concentrates on what its mandate and design equip it to do, and steps back where others are better placed. | **Protect what cannot readily be rebuilt**: Global standards, prequalification, emergency authority, global health data, market shaping, and civil registration and vital statistics. |
| Four Implications, each drawn from the evidence | **Evidence 1** Function overlap: lack of coherence in funding for country systems has created separate processes that shift the cost of coordination onto countries, and the external offer does not build lasting national capacity. | **Evidence 2** Funding rewards short-term results that one funder can claim, and each funder times transitions on its own terms. |
| | Implication 1 - PRIORITY **Centre the future global health architecture around countries** | Implication 2 **Shift financing incentives and behaviours of external partners** |
| | **Evidence 3** Function gap: no organisation or arrangement can steward the architecture as a whole to ensure cross-system coherence, accountability and adaptability, and coverage is weakest where capabilities must connect across organisations and levels. | **Evidence 4** Function gap: Shared functions every country relies on whose results are hard to attribute are paid for by a few donors, cycle by cycle, and largely through earmarked funding. |
| | Implication 3 **Govern the global health system as a whole, and adapt it as needs change** | Implication 4 **Deliver and finance global functions and global public goods fairly and predictably** |

**Four decision lenses**.[13] Every reform choice is also a choice about equity, fragile and conflict-affected settings, the changing burden of disease and subsidiarity. The proposed 'lenses' are not separate reforms. The weight given to each changes how a reform is designed, how funds are used and which risks are acceptable, so the right balance will differ between contexts and over time (Figure 5). The lenses are also the way to nuance each Reform Objective to its context and to make its associated trade-offs explicit. Faster consolidation of external financing, for example, may cut costs for countries but put dedicated funding for marginalised groups at risk; a faster transition may strengthen national ownership but interrupt services before domestic funding is ready. Annex A shows how each Reform Objective could help or harm progress on each lens.

*Figure 5. The four decision lenses*

| Equity | Fragile and conflict-affected settings | The changing burden of disease | Subsidiarity and regional institutions |
|---|---|---|---|
| **What is at stake** Whether reforms reach the people most in need within countries, not only the poorest countries. | **What is at stake** Whether services continue where the state cannot deliver, and whether responsibility returns to national institutions. | **What is at stake** Whether capability and financing follow the health needs growing fastest: non-communicable diseases, mental health and ageing. Whether capability adapts to climate-related health risks. | **What is at stake** Whether each function sits at the level closest to countries where it works well: national, regional or global. |
| **Effect on reform design** More weight favours ring-fenced funding for marginalised groups and slower, protected transitions; less weight favours simpler, faster consolidation. | **Effect on reform design** More weight justifies direct delivery through UN and non-state partners and a higher tolerance of risk; less weight favours country systems everywhere. | **Effect on reform design** More weight shifts funding and market shaping towards new product areas and primary health care; less weight protects today's disease programmes. | **Effect on reform design** More weight moves functions and funding to regional and national bodies; less weight keeps them global for scale and common standards. |
| Evidence: Finding 11 | Evidence: Finding 10 | Evidence: Finding 9 | Evidence: Finding 5 |

***Source:*** MOPAN Outputs 2 and 3. Findings are those of Output 2.

13 Principles apply in the same way to each Reform Objective. Lenses describe outcomes at stake in every reform, whose weight is a political choice that varies by context and strategy. Equity, for example, rests on a rights-based commitment that applies everywhere, but how it is weighed against other aims in the design of a particular reform is a choice that should be made explicit.



# Ten Reform Objectives

***Image credit:*** GAVI, 2012, John Bompengo

Each Reform Objective concerns how the organisations work together across the architecture, and can be taken forward in more than one way. Below, the Reform Objectives associated with each Implication are detailed, starting with the evidence, followed by tables setting out what would change, what would stop, options by degree of change to the system, the risks and what the Reform Objective implies for the multilateral organisations in the study.

Comparative advantage implications for organisations are proposed based on assessed mandate and design, not on judgements of performance. Options are described on a three-step scale of change to the system: *align* (organisations keep their own arrangements but bring them into line with each other and with national systems), *integrate* (shared arrangements replace separate ones) and *reshape* (roles, funding or mandates are reallocated across the system). These are not a sequence, for instance it may be more efficient to consolidate than align.

Some steps need no reform at all. Box 1 sets out ways of working that organisations and funders can adopt now.

**Box 1. Ways of working that can start now, without wider reform**

Some findings call less for reform than for organisations and funders to apply what already works consistently. These steps need no new mandate or institution, and can start now:

- **Put shared roles in writing.** Where roles are written down, specifically financed and agreed, comparative advantage is realised, as the health products chain shows. The same discipline can be applied wherever organisations share a function.
- **Agree the division of labour in fragile settings.** Agree who does what in crises from the outset, including the route back to national leadership.
- **Clarify roles across levels.** In detection, alert and response, agree what is done globally, regionally and nationally where regional institutions are ready and financed, without reproducing global fragmentation at regional level.
- **Lean in where comparative advantage is strongest.** Organisations and funders can direct effort and money to those best placed for each function, and step back where others are better placed (see Table 8).
- **Hold one position across government.** Each funder can develop a consistent position across its various decision points (for example, in different boards and governing bodies).

# Implication: Centre the future global health architecture around countries

Countries carry much of the cost of an architecture that was never designed as a whole. The evidence showed that separate organisational modalities and requirements create duplication and shift transaction costs onto countries, and that collective capabilities to support country systems are substantial but do not combine as a coherent offer or support long-term institutional development. Reform Objectives therefore focus on consolidating the ask of countries with one plan, one financing process and one set of assurance and reporting requirements, and ensuring support strengthens national institutions rather than replacing them.

## 1. Consolidated external financing for health systems in each country

**The evidence**: Up to five global funds and agencies run parallel schemes for similar health-system purposes, each with its own application, appraisal, assurance, audit, co-financing and reporting. Joint audits are rare. **Associated Functions:** F2, F6.

| **What would change**: | **What would stop**: |
|---|---|
| Funders agree one application, appraisal, assurance framework, audit and reporting line for external health-systems financing in each country, led by the government. An assessment or audit accepted by one organisation is accepted by the others. Once a compact is in place, health-systems financing is pooled in the country in support of the national strategy it defines, preferably alongside a longer-term programme led by the World Bank or a regional development bank. | Separate applications, appraisals and reporting for each fund. Repeated fiduciary assessments and audits of the same national systems. Parallel project management units; country teams of different funds working to separate plans; and country missions by different funders at different times. |

**STEPS**:

| **ALIGN**: | **INTEGRATE**: | **RESHAPE**: |
|---|---|---|
| Harmonise at the country interface: one application, calendar and assurance framework; mutual reliance on audits. | Pool health-systems funding in a government-led mechanism or on-budget sector support, with ring-fenced funding for marginalised groups. | Consolidate external health-systems financing at global level into one channel, led by those best placed for long-term institution building. |

| **Risks**: | **Comparative advantage implications for the multilateral organisations**: |
|---|---|
| Weak fiduciary capacity in some countries. Merging streams should not drop dedicated funding for marginalised or criminalised groups. Assurance standards must not fall. Transition costs are front-loaded. | The World Bank and the GFF, whose design combines long-term, on-budget financing with relationships with finance ministries, are best placed to anchor consolidated health-systems financing, though the GFF's reach is limited by its current model. Disease-focused funds (Global Fund, Gavi) would follow one of the three steps and shift, at the strategic level, to concentrate on what their design does best (i.e. commodities, market shaping and community-led programmes). World Bank fiduciary standards could provide a basis for mutual reliance. The multilateral development banks' advantage lies in long-term institution-building finance, not in technical assistance in health, so TA for health-systems strengthening must also be available and funded. As Output 2 found, TA should move closer to countries; where necessary, WHO, other UN bodies and the global health initiatives, which have funds and comparative advantage in specific areas, could provide it. |

## 2. One country compact, binding on all partners

| | | |
|---|---|---|
| **The evidence**: Each organisation plans its support separately, with its own priorities, timelines and reporting, so there is no single external offer for a country's health system. **Associated Functions:** F2, F6. | | |
| **What would change**:<br>The government chairs one compact, with one plan and budget that all partners follow, including sub-national levels. Commitments bind funders as well as government, within the limits of the funding pledged to them. Shared benchmarks for the quality of external assistance (alignment, predictability, use of country systems, capacity left behind) are reported publicly and used in funding and board decisions. Civil society and affected communities have a formal role. Governments commit in turn to raise their own health spending, expand domestic resource mobilisation, strengthen public financial management, and use the compact to hold partners to account for changing their behaviour. Accountability runs both ways. | | **What would stop**:<br>Organisation-specific country plans and stand-alone compacts alongside the national process. Separate, organisation-specific assessments of the quality of support. |
| **STEPS:** | | |
| **ALIGN**:<br>A shared plan with voluntary partner commitments. | **INTEGRATE** :<br>Binding commitments with an annual joint review against the benchmarks. | **RESHAPE**:<br>Funders' boards link allocations to compact commitments and benchmark results. |
| **Already under way**: Government-chaired country compacts; Lusaka Agenda Monitoring and Accountability Framework. | | |
| **Risks**:<br>Assumes a government able to lead health, finance and sub-national authorities must agree first. Measures must be simple and must not add to reporting burdens. | **Comparative advantage implications for the multilateral organisations**:<br>Applies to all nine. WHO's country presence and the GFF's country-platform model can support governments to run the compact. Funds without country presence (Global Fund, Gavi, Pandemic Fund, Unitaid) would commit through the compact rather than through separate country mechanisms, and their boards would hold management to account for compact commitments. | |

## 3. A defined, complementary role for external support

**The evidence**: This reform objective applies across development assistance for health; the evidence identified two particular areas of focus: technical assistance and FCAS. Technical assistance is contracted funder by funder. In fragile settings crisis arrangements can inhibit the route back to national leadership. **Associated Functions:** F2, F5.

| **What would change**: | **What would stop**: |
|---|---|
| Agreed rules on when external delivery is justified and how responsibility returns to national institutions. Countries set priorities for technical assistance and control more of its resources, for example through pooled or government-managed technical assistance funds. In fragile settings, a route back to national leadership is agreed from the start. | Parallel delivery where national systems work. Technical assistance contracted separately by each funder. Crisis arrangements without an agreed exit route. |

**Already under way**: Benchmarks and indicators tracking external funding flows proposed in the Lusaka Agenda Monitoring and Accountability Framework (Africa CDC)

**STEPS**:

| **ALIGN** : | **INTEGRATE**: | **RESHAPE**: |
|---|---|---|
| One joint technical assistance plan per country. In fragile settings, partners agree from the outset how support will move from direct delivery back to national and local institutions. | A pooled technical assistance fund under government direction. In fragile settings, external partners shift towards supporting national and local actors to deliver, using innovative and catalytic approaches where state capacity is weak. | All external technical assistance for health systems channelled through country-led arrangements, with regional institutions as providers where appropriate. In fragile settings, any direct delivery is time-bound and steps back as national capacity returns. |

| **Risks**: | **Comparative advantage implications for the multilateral organisations**: |
|---|---|
| Must not lead to premature withdrawal where no government can deliver. Country control should not reduce quality or close off access to independent expertise. | UNICEF and UNFPA, whose design enables operational reach in fragile settings, are well placed to focus on supporting national and local actors to deliver, and to use innovative and catalytic approaches where state capacity is weak. Both may already do much of this; the evidence reviewed does not show how consistently. WHO's technical support concentrates on national strategy, health financing and norms. The global health initiatives (the Global Fund, Gavi and the Pandemic Fund) finance a large share of technical assistance and the jobs that go with it; channelling it through country-led arrangements would turn this reservoir of expertise into a resource for national priorities. Regional institutions such as Africa CDC can become technical assistance providers where ready and financed. |

# Implication: Shift financing incentives and behaviours of external partners

The evidence showed that financing incentives have shaped comparative advantage by building capabilities where funders can see and attribute results and concluded that changing financing incentives is a key lever for changing what organisations do. Funding for health systems tends to cover running costs on programme timetables rather than build institutions that last[14], the architecture is slow to shift towards changing health priorities, and each funder sets its own transition terms, so a country can face several transitions at once. Reform Objectives therefore focus on longer financing horizons for the national institutions on which health systems depend, and one co-financing and transition pathway per country, so that the shift to domestic financing protects services and people.

## 4. Longer financing horizons for national institutions

<table>
<tr><td colspan="3">The evidence: The national institutions on which health systems depend are largely funded through short programme cycles, and results frameworks count outputs that funders can attribute rather than lasting capacity. Associated Functions: F2.</td></tr>
<tr><td colspan="2">What would change:<br>Financing of ten years or more for national institutions such as health financing, audit, statistics, budget and supply-chain bodies, tapering in planned steps. Results frameworks recognise contributions to shared results and prevention, not only attributable outputs.</td><td>What would stop:<br>Short project cycles as the main way of paying the running costs of national institutions. Results frameworks that count only attributable outputs.†</td></tr>
<tr><td colspan="3">STEPS:</td></tr>
<tr><td>ALIGN:<br>Commitments of five years or more, aligned with national plans.</td><td>INTEGRATE:<br>Ten-year commitments with increasing co-financing.</td><td>RESHAPE:<br>Long-horizon pooled financing for national institutions through the consolidated channel (Reform Objective 1).</td></tr>
<tr><td colspan="3">Already under way: Some multi-year, on-budget World Bank and GFF operations linked to national plans. Increased use of blended finance models including with GHIs</td></tr>
<tr><td>Risks:<br>Support must still end in a planned way. Long commitments should not lock in today's priorities.</td><td colspan="2">Comparative advantage implications for the multilateral organisations:<br>The World Bank (long-term IDA financing) and the GFF are designed for long horizons and support countries to incrementally advance their recurrent expenditure on health. Disease funds and Gavi would adapt results frameworks to credit shared outcomes, prioritise integration and strengthen national functions including through shifting recurrent expenditure support to WB. Funders would change the metrics in replenishment investment cases.</td></tr>
</table>

† Output 2, Finding 2.

14 Output 2, Findings 2 and 6, and Annex G on country health systems (F2).

## 5. Harmonised co-financing and transition pathway

<table>
<tr><td colspan="3">The evidence: Services for marginalised groups are most at risk at exit, countries need time and planning space to lever their own domestic financing, and unmet co-financing has led to stock-outs. Associated Functions: F2, F3.</td></tr>
<tr><td colspan="2">What would change:<br>One government-led transition plan per country that all funders follow, with coordinated timelines and gradual glide paths. Countries keep access to pooled prices after support ends. Public, pooled domestic funding, not out-of-pocket payments, replaces external support. Each plan sets out the domestic financing path that replaces external support, with rising public spending on health and stronger revenue and public financial management systems.</td><td>What would stop:<br>Separate co-financing calendars and transition clocks that start and end without coordination.</td></tr>
<tr><td colspan="3">STEPS:</td></tr>
<tr><td>ALIGN:<br>Coordinate calendars and share exit dates for each country.</td><td>INTEGRATE:<br>One government-led transition plan per country.</td><td>RESHAPE:<br>A system-wide framework for eligibility, co-financing and transition, with a joint bridging facility.</td></tr>
<tr><td colspan="3">Already under way: Pooled procurement open to self-financing countries (wambo.org; UNICEF and UNFPA procurement); Accra Reset motivating for rapidly building sovereignty and self-reliance.</td></tr>
<tr><td>Risks: A faster or uniform timetable could end services before domestic funding is ready, or shift costs onto households. Services for marginalised groups need protection that does not depend on government funding.</td><td colspan="2">Comparative advantage implications for the multilateral organisations:<br>All co-financing arrangements need to be coordinated. Gavi and the Global Fund, which have the most developed transition and co-financing policies, align into one pathway. UNICEF, UNFPA and the Global Fund's pooled procurement enable transitioned countries to continue to access pooled prices. The World Bank and GFF can support through financing the bridge on budget. Further analysis is needed on bridging approaches to ensure protection for marginalised groups.</td></tr>
</table>

## Implication: Govern the global health system as a whole, and adapt it as needs change

No one organisation or arrangement has the authority to steward the global health architecture as a whole, and stewardship, including reform of the system, cannot rest with the organisations themselves. Coverage of the six functions is weakest where capabilities must connect across organisations and across global, regional and country levels, and the architecture has been slow to respond as health needs and regional roles shift. Comparative advantage adds most where roles are deliberately agreed.

## 6. Integrated market shaping across essential products

| | | |
|---|---|---|
| **The evidence**: The weak links in an otherwise well-configured chain are new product areas, such as medicines for non-communicable diseases and mental health; several buyers approaching the same suppliers; and links to regional procurement and manufacturing. **Associated Functions:** F1, F3. | | |
| **What would change**:<br>Agreed priority products and a written division of labour along the chain, extended to products for non-communicable diseases, mental health and reproductive health. Joint forecasting and negotiation where buyers overlap. Governments, including those that have transitioned, buy through shared channels with their own budgets. Stronger links to regional procurement and manufacturing. | | **What would stop**:<br>Separate forecasting and negotiation with the same suppliers for the same products. New product areas left without anyone responsible for market shaping. |
| **STEPS**: | | |
| **ALIGN**:<br>A written division of labour and an agreed priority list. | **INTEGRATE**:<br>Joint forecasting and negotiation across platforms. | **RESHAPE**:<br>An integrated commodities platform, with market shaping led by those best placed. |
| **Already under way**: Malaria vaccine partnership, Dual AI Nets project, UNFPA – Unitaid collaboration on carbetocin and tranexamic acid, Gavi Leap. | | |
| **Risks**:<br>Protect what works no disruption to supply, no loss of specialist expertise, and continued attention to smaller programmes. Concentration risk related to lack of diversity. | **Comparative advantage implications for the multilateral organisations**:<br>Build on existing roles — WHO prequalification extended to products for non-communicable diseases; Unitaid as pathfinder for new product areas; UNICEF, UNFPA and wambo.org as channels open to governments; Gavi and the Global Fund coordinating demand financing with shared suppliers. | |

## 7. A standing arrangement to oversee roles and mandates

**The evidence**: Mandates have grown, but none has ever been formally reduced, and nobody can ask whether a function is already performed elsewhere. No organisation can direct its independently governed peers. Regional institutions are taking on functions without a corresponding role in governance. **Associated Functions:** F6.

| | |
|---|---|
| **What would change**:<br>A standing arrangement, built on existing bodies, agrees who does what and at which level (global, regional or national), how mandates change and when functions close. It is informed by regular independent reviews of the whole system and foresight to assess emerging trends and evolving needs, adjusting roles in line with these changes. Regional institutions take part, and civil society and other funders, including philanthropies, have a voice. | **What would stop**:<br>Mandates that grow without review. Coordination forums the new standing arrangement makes redundant, simplifying coordination architecture. New institutions created without assessing existing capacity. |

**STEPS**:

| | | |
|---|---|---|
| **ALIGN**:<br>A periodic independent review of the whole system by a panel whose authority rests on its members' credibility, as with the Global Preparedness Monitoring Board, reported to the World Health Assembly and governing boards. | **INTEGRATE**:<br>A standing committee including governing-body chairs, major funders and independent expertise that acts on review findings, including on which functions move to regional institutions. | **RESHAPE**:<br>A political agreement at the highest level among a representation of member states, boards and major funders on how roles are allocated, linked to replenishment and funding decisions and building on existing bodies. No new permanent structure is proposed. |

| | |
|---|---|
| **Risks**:<br>Needs real authority to be more than another coordination meeting. Conflicts of interest. No new supranational bureaucracy. | **Comparative advantage implications for the multilateral organisations**:<br>Suggests starting with an independent stewardship function, able to assess the whole system so that no single organisation judges its peers. Its findings would be reported to individual boards to execute through their governance structures, including the World Health Assembly, whose universal membership, convening authority and WHO's constitutional coordinating role can support follow-up. All other actors would commit to act on its findings. |

## 8. System-wide oversight of funding flows

| | | |
|---|---|---|
| **The evidence:** Funding between organisations does not follow agreed roles and is not mapped. Replenishments for Gavi, the Global Fund and the Pandemic Fund, and WHO's investment round, fell in the same period and competed for the same donors. **Associated Functions:** F6. | | |
| **What would change:**<br>A public map of funding flows into, between and out of the organisations. A joint replenishment calendar and a shared investment-case framework, with options for joint pledging. Funding would follow so organisations with agreed roles are resourced to deliver. | | **What would stop:**<br>Unsynchronised replenishments competing for the same donors. Funding flows between organisations that no one maps. |
| **STEPS**: | | |
| **ALIGN:**<br>An annual system-wide funding report built on existing OECD data. | **INTEGRATE:**<br>A joint replenishment calendar and common investment-case metrics. | **RESHAPE:**<br>A single pledging moment for global health, with allocation by agreed roles. |
| **Already under way:** Benchmarks proposed in the Lusaka Agenda Monitoring Framework (Africa CDC); OECD data on multilateral funding flows. | | |
| **Risks:**<br>Coordination must not slow funding decisions or entrench separate replenishments. One single pledging moment may result in further reduced total external assistance commitments. | **Comparative advantage implications for the multilateral organisations:**<br>The World Bank, as trustee and host for several funds, can map flows with OECD DAC data. Gavi and the Global Fund would align replenishment timing, and the Pandemic Fund the timing of its resource mobilisation, leveraging their resource mobilisation capability for future functions. Donors act through the boards on which they sit. | |

***Source:*** MOPAN Outputs 1 and 2.

## Implication: Deliver and finance global functions and global public goods fairly and predictably

Shared global functions, many of them global public goods, are the least protected.[15] Comparative advantage is least well supported where results are shared, difficult to attribute or hard to demonstrate, and these functions depend on a small group of donors and on earmarked funding renewed cycle by cycle. The evidence shows that the gaps lie in functions that no one is assigned to or funded to deliver as a whole.

### 9. Joint financing for shared global functions

**The evidence:** Shared functions every country relies on whose results are hard to attribute are paid for by a few donors, cycle by cycle, and largely through earmarked funding. For example, WHO is irreplaceable at the centre of many shared functions but structurally underfunded, with most of its income earmarked. **Associated Functions:** F1, F4.

| **What would change:** | **What would stop:** |
|---|---|
| Shared global functions are defined and costed, for example, standards, prequalification and quality assurance, international alerts, health estimates and the national data systems beneath them. They are financed predictably and jointly, with every country contributing and other funders paying a fair share. | Cycle-by-cycle earmarked funding for the same shared functions. Financing global public goods as development aid to selected countries. |

**STEPS**:

| **ALIGN:** | **INTEGRATE:** | **RESHAPE:** |
|---|---|---|
| Define and cost the functions; Donors commit flexible, multi-year funding. | A ring-fenced window for shared functions to which all countries contribute. | Assessed contributions and other collective financing mechanisms cover shared functions in full, scaled by capacity to pay. |

**Already under way:** Member states' discussion to raise assessed contributions to 50% of WHO's base budget by 2030–31 (needs agreement). Global Public Investment thinking and strategies are in development and could help guide decisions about competing priorities.

| **Risks:** | **Comparative advantage implications for the multilateral organisations:** |
|---|---|
| Must not draw funding away from country programmes. A fixed list of functions could lock in today's priorities to the detriment of new priorities. | Suggests WHO concentrates its resources on functions only it can perform (norms, prequalification, alerts), financed through assessed and flexible contributions. Organisations that now fund these functions through earmarked grants to WHO would contribute through the joint arrangement. Other shared functions, including market shaping and health estimates co-produced with UNICEF, UNFPA and the World Bank, are financed jointly. |

15 Output 2 differentiates *global health functions* as describing what needs to be done; *global public goods* as benefits that reach every country at once and cannot be withheld from any, such as international norms, prequalification and alerts; and *development assistance for health* as financing modality: one way of paying for both global functions and support to individual countries, not a function in itself.

## 10. Shared detection, alert and response

| | | |
|---|---|---|
| **The evidence:** The alarm is strong but integration is weak: disease, civil registration, regional and global data are not joined up, and surveillance is often funded country-by-country as aid. **Associated Functions:** F4, F5. | | |
| **What would change:**<br>Interoperable country, regional and global data systems with a single reporting repository for countries. Agreed roles across levels and in crises. Core detection functions financed as a shared global function for all countries. | | **What would stop:**<br>Separately funded, disease-specific surveillance systems that do not connect. Multiple reporting streams for the same data. |
| **STEPS**: | | |
| **ALIGN:**<br>Common data standards and interoperability. | **INTEGRATE:**<br>One data repository across levels, with predictable funding for core functions. | **RESHAPE:**<br>A jointly financed global network that replaces disease-specific surveillance funded as aid. |
| **Risks:**<br>Countries must keep ownership of their data; in conflict settings others may need to hold data for a time. Global fragmentation must not be reproduced at regional level. | **Comparative advantage implications for the multilateral organisations:**<br>WHO leads on standards and alerts, with Africa CDC and other regional institutions taking regional roles where ready and financed. The Pandemic Fund, designed to integrate rather than duplicate, finances integration of surveillance and laboratory systems rather than new parallel ones. Disease funds fold surveillance funding into the shared system so that investment lifts all programmes. | |

***Source:*** MOPAN Outputs 1 and 2.



# Taking the reforms forward

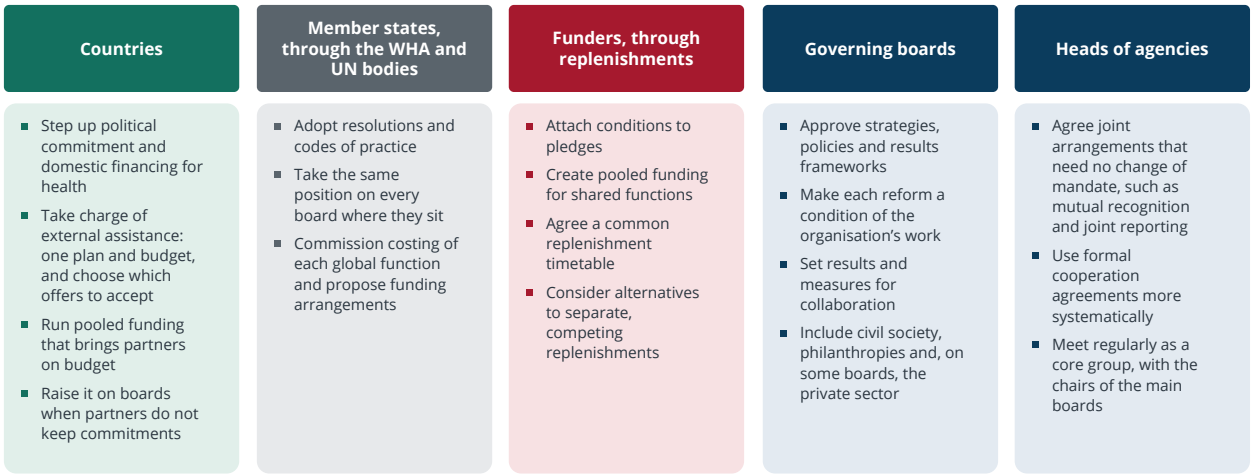
How each reform is taken forward will depend on context, political will and the weight given to the decision lenses. Support will also need to be differentiated: its level, form and duration will vary with each country's income, capacity and fragility, and country compacts and transition pathways should reflect this. This chapter offers a structure for that discussion rather than a blueprint. For each Reform Objective it asks four questions:

- Who holds the levers to make reform happen?
- What benefit would reform bring, and how complex would it be?
- How feasible is it and what would the change cost?
- Where could it start?

## Who holds the levers

Most Reform Objectives require the use of several levers at once, held by countries, member states acting through the World Health Assembly and UN bodies, funders through replenishments, governing boards and heads of agencies (Figure 6). When governments take charge of external assistance and increase their own funding for health, the other levers carry more weight. Some levers are underused. For example, the heads of the main financing and technical agencies (for example the Global Fund, Gavi, the GFF, the World Bank and WHO) no longer meet systematically, nor do the chairs of the main boards. Regular meetings of a small core group could add value giving a place where levers connect. Boards could set results and measures for collaboration between organisations. Funders could jointly consider alternatives to separate replenishments, which set organisations to compete for the same donors. Governments that sit on boards can also raise it there when partners' behaviour does not match their commitments.

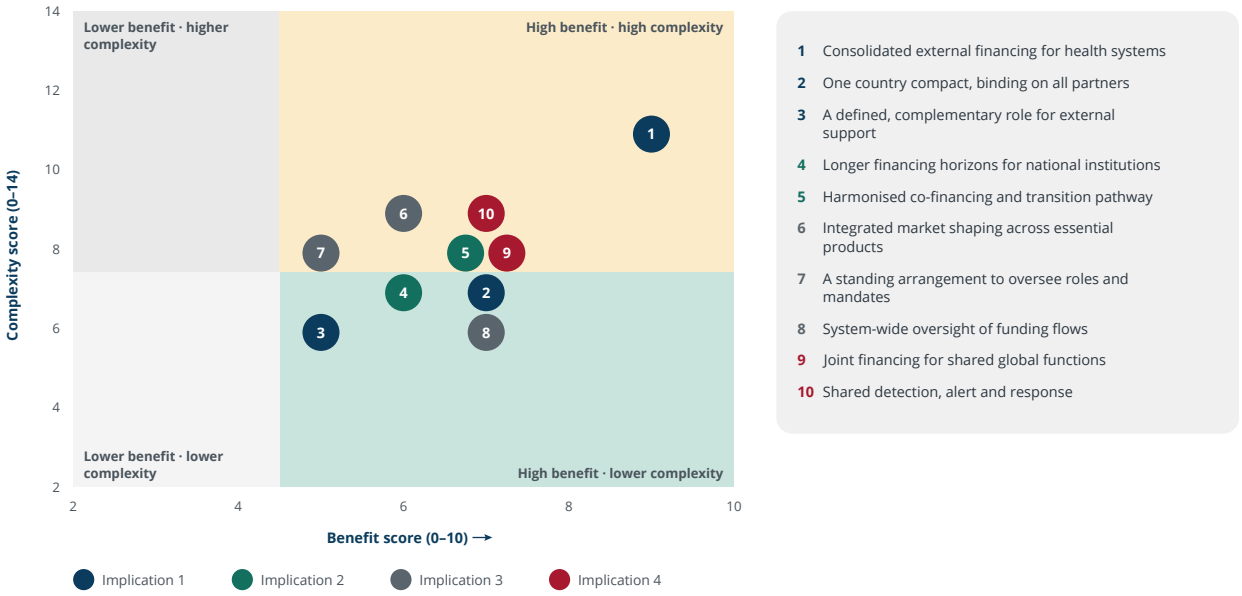
***Figure 6. Who can make the reforms happen***



## Weighing reform benefit and complexity

Reform benefit and complexity can be scored from the evidence (Figure 7). The scores describe each reform objective in its fullest form, at the *'reshape'* end of the scale of change used in chapter 3; steps that *align* or *integrate* existing arrangements are less complex and deliver part of the benefit. Feasibility and the cost of change depend on political will and on design choices. The judgements here are a first view, to be tested with the governments, boards and funders who would take the decisions. The tool is intended to support discussion of the options, not to rank them: its dimensions, scales and weights can be adjusted. The tool components and an initial heat map are in Annex B. Users can reweight the criteria, add dimensions such as time, score the Reform Objectives with countries, organisations and member states, and repeat the exercise as conditions change, revising the judgements in Table 5 in the same way.

***Figure 7. Complexity and benefit of the Reform Objectives***




***Notes:*** Scores are provisional judgements based on the evidence, for each reform objective in its fullest (reshape) form. Merged Reform Objectives (1 and 2) take the higher score on each criterion of their components.

***Source:*** Annex B. Reform complexity and benefit scoring tool

The chart maps the landscape of options; it does not set a sequence. Consolidated external financing for health systems in each country is both the most beneficial and the most complex Reform Objective, because it involves every major funder and their rules and procedures. Six Reform Objectives combine high benefit with high complexity and need sustained political support; four bring high benefit with lower complexity, and none is complex with low benefit. Within Reform Objectives 1 and 2, mutual recognition of assurance and audit and benchmarks for the quality of external assistance are quicker first steps that contribute to making the others possible.

## Feasibility, cost of change and levers

Table 5 brings together, for each Reform Objective, where it sits on benefit and complexity, a first judgement of feasibility, the likely cost of change and who holds the levers. The judgements are tentative and should be revised as discussion with decision-makers proceeds.

*Table 5. Taking the Reform Objectives forward: feasibility, cost of change and levers*

| Reform Objective | Benefit and complexity (fullest form) | Feasibility: first judgement | Cost of change (money, staff time, risk) | Who holds the levers |
|---|---|---|---|---|
| 1. Consolidated external financing for health systems | **High benefit · high complexity** First step (mutual recognition) is quicker | Widely supported aim; resisted where funding models rely on separate, attributable channels. | High: dual running; systems rebuilt | Boards; agency heads; funders; countries; WHA |
| 2. One country compact, binding on all partners | **High benefit · lower complexity** Benchmarks are a quicker first step | Builds on compacts under way; binding partner commitments are the test. | Moderate: falls mainly on governments although all partners need to agree the content and terms. | Countries; boards; WHA |
| 3. A defined, complementary role for external support | **High benefit · lower complexity** | Boards must agree rules on direct delivery and technical assistance. | Moderate; highest in fragile settings | Boards; countries |
| 4. Longer financing horizons for national institutions | **High benefit · lower complexity** | Technically simple; harder politically, as results cannot be claimed alone. | Low; mainly political | Funders; boards |
| 5. Harmonised co-financing and transition pathway | **High benefit · high complexity** | Countries support; funders with different scopes likely to resist common rules. | Moderate to high if timing slips | Boards; funders; countries; WHA |
| 6. Integrated market shaping across essential products | **High benefit · high complexity** Agreeing roles is a quicker first step | Agency heads can agree roles; joint negotiation touches procurement models. | Moderate: supply risk if roles change fast | Agency heads; boards |
| 7. A standing arrangement to oversee roles and mandates | High benefit · high complexity | Widely proposed; resisted where it limits board autonomy. | Low if built on existing bodies | WHA; boards |
| 8. System-wide oversight of funding flows | **High benefit · lower complexity** Joint pledging would be more complex | A funding map is feasible with existing data; joint pledging would be resisted. | Low: retiming set cycles | Funders; boards; WHA |
| 9. Joint financing for shared global functions | **High benefit · high complexity** | All countries must agree; functions must first be defined and costed. | Moderate: earmarked funding continues meanwhile | WHA; funders |
| 10. Shared detection, alert and response | **High benefit · high complexity** | Needs agreement on data and roles across levels; the International Health Regulations and the Pandemic Agreement give a frame. | Moderate: keep surveillance running | WHA; agency heads; regional bodies |

***Notes:*** Benefit and complexity refers to each Reform Objective in its fullest form (the reshape end of the scale of change in chapter 3); first steps that align or integrate are less complex. Placements are provisional; merged Reform Objectives take the higher score on each criterion of their components (Annex B). Cost of change is the cost of moving to the new arrangement – money, staff time and the risk of disruption to services – not the running cost of the arrangement itself. Feasibility and cost of change are MOPAN's first, qualitative judgements and need testing with decision-makers. Boards act separately; the World Health Assembly (WHA) is where governments can agree positions that apply across the boards on which they sit.

## Implications for each multilateral organisation

The tables in Chapter 3 set out, one Reform Objective at a time, what each reform implies for the organisations. Table 8 reads the other way: it brings together what the ten Reform Objectives suggest for each of the nine. The Implications rest on each organisation's mandate and design as assessed, not on judgements of performance, and they describe a direction rather than a prescription. Regional institutions such as Africa CDC and the African Medicines Agency are outside the nine, but Reform Objectives 3, 7 and 10 would give them a larger role.

***Table 6. What the Reform Objectives suggest for each organisation***

| | Comparative advantage to deliver Reform Objectives | Examples of what it would do differently or less | Reform Objectives |
|---|---|---|---|
| WHO | Norms, standards, prequalification and international alerts; declaring and coordinating emergencies; leading the production of health financing information and co-producing the health data the system plans against; anchor for coordinating independent stewardship follow-up; technical support on national strategy and health financing to member states. | Concentrate resources on functions only it can perform; depend less on earmarked funding; support governments to run country compacts rather than parallel programmes. | **2, 3, 6, 7, 9, 10** |
| UNICEF | Procurement, supply and delivery at scale, including in fragile settings; co-producing the child-health and equity data the system plans against; providing technical assistance on national primary health care. | Keep countries that have moved on from external support able to buy at pooled prices and strengthen how it open its procurement channels to governments; in fragile settings, agree with governments when to deliver directly and how to hand responsibility back; and produce child health estimates with partners as shared functions. | **2, 3, 5, 6, 9** |
| UNFPA | Sexual and reproductive health and gender-based violence; procurement of reproductive health commodities; co-producing sexual and reproductive health data that the system plans against; census and civil registration. | Concentrate on sexual and reproductive health (including maternal health), gender-based violence and population data, where its mandate is distinctive; continue and amplify engagement in fragile and conflict-affected settings; and produce maternal health and population estimates with partners as shared functions. | **2, 3, 5, 6, 9** |
| World Bank | Long-term, on-budget financing through finance ministries; multiple tools and modalities to support domestic resource mobilisation and transition; fiduciary standards as a basis for mutual reliance; its role as trustee and host for several funds. | Anchor consolidated health-systems financing with partners; finance transition bridges on budget, including recurrent expenditure; map funding flows across the system; co-produce health estimates with partners as shared functions. | **1, 2, 4, 5, 8, 9** |

| | Comparative advantage to deliver Reform Objectives | Examples of what it would do differently or less | Reform Objectives |
|---|---|---|---|
| GFF | Government-led country platforms and joint financing frameworks linked to World Bank financing, with a specialist focus on reproductive, maternal, newborn, child and adolescent health. | Extend its platform model to support country compacts, recognising that its reach is limited by its current model; expand model to enable more bilateral pooled funding in countries; help finance transition bridges on budget, without diluting its focus. | **1, 2, 4, 5** |
| Global Fund | Large-scale financing for health, pooled procurement and market shaping, and the voice of communities and civil society in governance. | Strategically orient itself towards its comparative advantage and in the meantime consolidate its health systems financing with others (at global and / or country level); commit to working through country compacts; align co-financing and transition pathway with Gavi and others; align replenishment timing; credit shared results; fold surveillance funding into shared systems; channel the technical assistance it finances through country-led arrangements; ensure countries are supported to embed community voice in national structures. | **1, 2, 3, 4, 5, 6, 8, 10** |
| Gavi | Vaccine financing, demand pooling and market shaping; a developed co-financing and transition model; a strong equity focus. | Strategically orient itself towards its comparative advantage and in the meantime consolidate its health systems financing with others (at global and / or country level); commit to working through country compacts; align co-financing and transition pathway with Global Fund and others; coordinate demand with shared suppliers; align replenishment timing; credit shared results; channel the technical assistance it finances through country-led arrangements; ensure countries are supported with effective last mile strategies within primary healthcare delivery. | **1, 2, 3, 4, 5, 6, 8** |
| Pandemic Fund | Disease-agnostic preparedness financing with equal donor and recipient representation and a co-investment requirement that embeds country ownership at the point of finance. | Finance the integration of surveillance and laboratory systems rather than new parallel ones; commit through country compacts; align its co-investment requirement with other co-financing rules; align the timing of its resource mobilisation with others' replenishments; channel the technical assistance it finances through country-led arrangements. | **1, 2, 3, 5, 8, 10** |
| Unitaid | Pathfinder for new products: evidence, early market entry and the Medicines Patent Pool, working with larger buyers. | Take the pathfinder role into new product areas, such as medicines for non-communicable diseases and mental health; commit through country compacts where it supports country work. | **2, 6** |

***Source:*** MOPAN Outputs 2 and 3. Based on mandate and design (Output 2, Table 4), not on assessments of performance.

## Where to start: two tracks

Rather than taking all ten Reform Objectives forward at once, this analysis proposes starting with two tracks that run in parallel.

**A country track.** One country compact, binding on all partners, with benchmarks for the quality of external assistance (Reform Objective 2); consolidated external financing for health systems in each country, starting with mutual recognition of assurance and audit (Reform Objective 1); and a harmonised co-financing and transition pathway (Reform Objective 5), so that the shift from external to domestic financing is planned together and protects services and people.

**A global track.** Joint financing for the shared global functions every country relies on (Reform Objective 9), and stewardship through a standing arrangement on roles and mandates (Reform Objective 7), backed by system-wide oversight of funding flows (Reform Objective 8).

Each track combines steps within reach with more complex ones, so that early progress can build momentum for the harder steps. The test of success is whether countries end up better able to plan, buy and pay for their own health priorities, with fairer access for the people most in need, and whether the functions every country relies on are secure and fairly financed.

## Making reform happen

No single actor can carry reform alone. For many governments, whether funders or implementing countries, the first step is a consistent position across their own ministries, so that what they encourage on one board they do not discourage on another. Reform is a two-way partnership that starts with countries, and civil society and communities have a critical role throughout.

MOPAN's evidence shows where the problems lie, why they persist and where each organisation is best placed. It does not seek to settle the political choices about pace, risk and priority that the decision lenses expose; those belong to the governments, boards and funders who take the decisions. The next steps are to contribute to the WHO-hosted Joint Process as its Task Force prepares its reports, and to test the judgements in this report with decision-makers. Several of the next steps proposed by the Accra Reset High-Level Panel, including one-stop country compacts, a single country interface for the main funds, joint decision points across boards, and the definition and costing of global public goods, offer early opportunities to take the Reform Objectives forward.

## Opportunities for further analysis

This report does not answer every question that reform raises, and further study would be useful in three areas. The first is **crises and equity:** how the reforms would work where government capacity is limited or authority is contested, and how reforms would benefit the people most in need within countries, not only the poorest countries. Further analysis could consider the trade-offs of each reform in more depth, and how to manage unintended consequences. The second is **emergency preparedness and response** beyond detection and alert. This could look beyond global health actors to consider the intersection with the humanitarian architecture. In emergencies, as across all of health, non-state actors are also vital to incorporate into planning, decision-making and delivery. The third is how the architecture should respond to the **changing burden of disease**, including non-communicable diseases, aging, mental health and the health effects of climate change. It could consider which aspects of the current architecture could be adapted whilst also considering the implications for existing priorities and constrained resources.

MOPAN will use the findings of this study to inform its future Performance Evidence Assessments of the nine multilateral organisations in scope. Furthermore, based on the findings of this study (limited to nine multilateral organisations), there would be scope to analyse the role of **regional development banks and organisations** applying the principle of subsidiarity to the reform options; further explore options for a **stewardship arrangement** including through exploring the track record of past mutual accountability mechanisms and cross organisation decision-making processes; assess the implications of **differentiation** within health-systems support including through exploring the mix of financing instruments such as blended finance arrangements to best support transition and long-term institution building in different contexts. These would be valuable subjects for future work by MOPAN or others.

# Annexes




***Image credit:*** Siavosh Hosseini | Unsplash

# Annex A. Taking reform forward: worked examples

This annex illustrates, for four Reform Objectives, one from each Implication, how each could be taken forward along the scale of change to the system used in chapter 3: align (organisations keep their own arrangements but bring them into line), integrate (shared arrangements replace separate ones) and reshape (roles, funding or mandates are reallocated across the system). The further along the scale, the more work and money flow to those best placed to do it, and the higher the complexity, the political sponsorship needed and the cost of change. The benefit and complexity scores in chapter 4 describe the reshape end of the scale. The tables in chapter 3 indicate, where the evidence allows, which organisations are best placed. The options are illustrations to support discussion, not recommendations. It ends by showing how each Reform Objective could help or harm progress on the four decision lenses.

***Table A A.1. Consolidated external financing for health systems in each country (Reform Objective 1, Implication 1)***

Today, many organisations contribute to country health systems but none leads, and up to five global funds and agencies may each run their own scheme in a country for essentially the same purpose in different thematic areas (Findings 6 and 8). The offer to countries on health systems is fragmented. The options move from harmonising these schemes to consolidating them.

| Option | What would change | What it asks of organisations and funders | Risks |
|---|---|---|---|
| **Align:** harmonise at the country interface | Funds keep their own pots and mandates but use one application, appraisal, assurance framework, reporting line and calendar, aligned to the national plan and budget. | Each fund's board changes its own rules; mutual recognition of assurance and audit (part of this Reform Objective). | Harmonised on paper but parallel in practice; the number of players does not fall. |
| **Integrate:** pool in country | Health-systems funding from the funds and agencies goes into one government-led pooled mechanism or on-budget sector support, backed by a joint technical assistance platform. Dedicated funding for priority diseases and populations is ring-fenced, while finding mechanisms to ensure that marginalised groups can still access funding. | Funders accept shared rather than attributable results. Organisations without an advantage in health systems strengthening fund through the pool instead of running their own programmes. | Fiduciary capacity where institutions are weak; dedicated funding for marginalised or criminalised populations that governments may not fund must be protected. |
| **Reshape:** consolidate before funding reaches the country | External financing for health systems is consolidated at global level into a single channel, led by those best placed for long-term institution building, with others contributing to it rather than running parallel schemes. Disease-focused funds concentrate where their advantage lies, such as commodities, market shaping and community-led programmes. | Board and replenishment decisions, changes to how mandates are interpreted, and agreed criteria for the lead role. | Concentration risk and slower disbursement; community voice and inclusion must be carried into the new channel; transition costs are front-loaded. |

*Table A A.2. Harmonised co-financing and transition pathway (Reform Objective 5, Implication 2)*

Today, each funder sets its own eligibility thresholds, timetables and exit terms, so a country can face several transitions at once, and services for groups which are criminalised, marginalised, or hard to reach are most at risk (Finding 11). The options move from coordinating exits to a single framework.

| Option | What would change | What it asks of organisations and funders | Risks |
|---|---|---|---|
| **Align:** coordinate calendars | Funders share eligibility thresholds, co-financing schedules and exit dates for each country, and avoid exits that coincide. Progress is tracked through existing sources such as WHO's Global Health Expenditure Database. Each funder keeps its own policy. | Information sharing and agreement to sequence exits; no change to eligibility rules. | Coordination without commitment; countries still face several sets of terms. |
| **Integrate:** one government-led transition plan per country | All funders sign up to one plan that sets which services move onto public financing and when, protects services for marginalised or criminalised populations that governments may not fund, and keeps access to pooled prices after support ends. | Funders adjust timetables to the plan while keeping policies suited to their scope; ministries of finance as well as health take part. | Plans not financed in the national budget; slippage, as when unmet co-financing has led to stock-outs. |
| **Reshape:** a single transition framework | One system-wide framework for eligibility, co-financing and transition across funders, with co-financing paid through the national budget and a joint facility to bridge gaps, so that external support exits as one. | Boards agree common eligibility and transition rules despite different scopes, and finance a joint bridging facility. | A uniform timetable could end services before public, pooled domestic funding is ready, or shift costs onto households. |

*Table A A.3. Integrated market shaping across essential products (Reform Objective 6, Implication 3)*

Today, the health products chain works where roles are written down and funded (Finding 3), but several buyers approach the same manufacturers, and new product areas such as medicines for non-communicable diseases are poorly covered (Finding 9). The options move from agreeing roles to a single integrated platform.

| Option | What would change | What it asks of organisations and funders | Risks |
|---|---|---|---|
| **Align**: agree roles and priorities | A written division of labour along the chain, from prequalification and market entry to demand financing and procurement, and an agreed list of priority products, extended through existing platforms to medicines for non-communicable diseases, insulin and mental health. | Heads of agencies agree roles; no change to mandates. | Priorities that follow today's large programmes and leave new product areas out. |
| **Integrate**: joint forecasting and negotiation | Existing platforms forecast together, negotiate jointly with the same suppliers and widen their product range. Governments, including those that have transitioned, buy through shared channels with their own budgets. | Data sharing between platforms; agreed rules on pooled negotiation and access. | Attention drifting from smaller programmes; links to regional procurement and manufacturing. |
| **Reshape**: a single integrated commodities platform | One platform for forecasting, negotiation and procurement of essential health products, with market shaping led by those best placed and others financing through it, linked to regional procurement and manufacturing. | Board decisions on procurement models and funding channels; transfer of functions between organisations. | Disruption to supply if roles change abruptly; concentration risk; loss of specialist expertise. |

*Table A A.4. Shared detection, alert and response (Reform Objective 10, Implication 4)*

Today, the alarm is strong but integration is weak: disease, civil registration, regional and global data are not joined up, and surveillance is often funded country by country as aid (Findings 5 and 10). The options move from connecting what exists to a jointly financed network.

| Option | What would change | What it asks of organisations and funders | Risks |
|---|---|---|---|
| **Align:** connect what exists | Common data standards and data interoperability across organisations' surveillance, civil registration and health information systems, and agreed roles for each organisation in a crisis. | Technical agreement among agencies and countries; no new financing. | Interoperability on paper only; countries must keep ownership of their data. |
| **Integrate:** one data stream across levels | Interoperable country, regional and global systems with a single reporting repository for countries, roles agreed between global and regional institutions where these are ready and financed, and predictable funding for core detection functions. | Agreement on roles across levels; financing commitments for regional institutions. | Reproducing global fragmentation at regional level; uncertain regional funding. |
| **Reshape:** a jointly financed global network | Detection, alert and response financed as a shared global function to which every country contributes, run as one network across country, regional and global levels, replacing disease-specific surveillance funded as aid. | All countries agree to contribute, for example through the World Health Assembly; disease programmes give up separate surveillance funding. | Drawing funding away from country programmes; in conflict, others may need to hold data. |

## Applying the decision lenses

Four decision lenses apply to every Reform Objective: equity; fragile and conflict-affected settings; the changing burden of disease; and subsidiarity and the role of regional institutions. Each is rooted in the evidence of Output 2: equity in the finding that funding reaches the poorest countries but not reliably the people most in need within them (Finding 11); fragile settings in the finding that results there follow what still functions (Finding 10); the changing burden of disease in the finding that collective capability is slow to adapt to the health burdens growing fastest (Finding 9); and subsidiarity in the evidence that regional bodies are taking on functions while regional roles and funding remain uncertain (Finding 5).

The lenses are not separate reforms. Whether a reform helps or harms progress on each depends on context, political commitment, financing and design, and the right balance will change over time. The table shows, for each lens, what progress would look like and how two Reform Objectives could help or harm it, depending on how they are designed and applied. Used in this way, the lenses help to nuance each reform to its context and to set out its trade-offs openly, so that those who take the decisions can weigh them.

*Table A A.5. The four decision lenses and the Reform Objectives*

| Decision lens | What progress would look like | Reforms that can support progress | Reforms that may bring risk to progress |
|---|---|---|---|
| **Equity:** Do reforms reduce inequities within and between countries? | Countries with weaker institutions can benefit from external support, not only those better able to use it. Results are reported by population group; developing countries gain fair access to new medicines and vaccines; transitions protect people. | 1 - Consolidated external financing: fewer processes make support easier to use for countries with weaker institutions. 5 Co-financing and transition: one planned exit, with continued access to pooled prices, protects services when support ends. | 1 - Consolidated external financing: merging funding streams could drop dedicated funding for marginalised or criminalised groups. 5 Co-financing and transition: a faster or uniform timetable could end services before domestic funding is in place. |
| **Fragile and conflict-affected settings:** Do reforms work in places affected by crisis, conflict or fragility, including those recovering from crisis? | Services continue through UN or non-state partners where government capacity is limited, with a plan to return responsibility to national institutions. Financing can be increased quickly when a crisis occurs. | 3 - Defined role for external support: sets out when external delivery is justified and how responsibility returns to national institutions. 10 Shared detection, alert and response: financing surveillance for all countries reaches settings that donor programmes often miss. | 3 - Defined role for external support: a strict rule against substitution could be used to withdraw support where no government can deliver. 10 Shared detection, alert and response: country-owned data systems assume a functioning state; in conflict, others may need to hold the data. |
| **The changing burden of disease:** Do reforms help countries respond to their own health risks as these change? | External support helps countries address non-communicable diseases, mental health, ageing, climate-related risks and new threats. Countries are funded to apply WHO guidance, and related products are available through pooled purchasing. | 9 - Joint financing for shared functions: funds countries to apply WHO guidance on non-communicable diseases and mental health, which is rarely funded now. 6 Integrated market shaping: agreed priorities could extend market shaping to products such as insulin and mental-health medicines. | 9 - Joint financing for shared functions: a fixed list of shared functions could lock in today's priorities. 6 Integrated market shaping: if priorities follow today's large programmes, new product areas could be left out. |
| **Subsidiarity and regional institutions:** Is each function carried out at the level closest to countries where it can be done efficiently and effectively? | Some global funding is transferred to regional bodies, not only to regional UN offices, as each body becomes ready, with reliable funding for regional institutions. | 4 - Longer financing horizons: gives national and regional institutions time to take on functions such as regulation and statistics. 7 Standing arrangement on roles and mandates: provides a place to decide when functions move to regional bodies, with the funding to match. | 4 - Longer financing horizons: long commitments through global channels could delay transfer to regional bodies. 7 Standing arrangement on roles and mandates: if global organisations and large funders dominate it, functions may stay at global level. |

***Source:*** MOPAN Outputs 2 and 3. Findings are those of Output 2.

# Annex B. Reform complexity and benefit scoring tool

This annex sets out how the decision tool works, the scales used to score the complexity and benefit of each Reform Objective, and the resulting scores.

## How the tool works, step by step

The decision tool asks four questions of each Reform Objective: what it would bring, how complex it is, how feasible it is and what the change would cost, and how it looks through the four decision lenses. Benefit and complexity can be scored from the evidence; feasibility and the cost of change must be judged with decision-makers. The tool is applied in six steps.

**Step 1. Score complexity.** Each Reform Objective is scored from 0 to 14 on five criteria: how many organisations and boards must agree (breadth), and how much must change in mandates, financing flows, organisation design and the role of countries. The scales are set out below.

**Step 2. Score benefit.** Benefit is scored from 0 to 10, separately for countries and for the system, on scales that describe observable change rather than intentions.

**Step 3. Lay out the scores.** A heat map shows the pattern across all the Reform Objectives at once, so that users can see where complexity comes from and where benefit falls.

**Step 4. Plot the reforms.** The Reform Objectives are plotted on a four-quadrant chart of benefit against complexity (Figure 7).

**Step 5. Judge feasibility and the cost of change.** These are judged with those who would take the decisions: whose agreement is needed and how willing they are, what would stop, and what the switch would cost in dual running, staff and risk to services. Table 5 in chapter 4 gives a first, tentative judgement for each Reform Objective, rooted in the evidence of Output 2 and the complexity scores.

**Step 6. Apply the decision lenses.** The most promising Reform Objectives are examined through the four decision lenses (chapter 2 and Annex A) before deciding how to design them.

## The scoring scales

Complexity is the sum of five criteria (maximum 14): low is 5 or under, moderate 6 to 8, high 9 or over. Benefit is the sum of two cumulative scales, for countries and for the system (maximum 10): low is 4 or under, moderate 5 or 6, high 7 or over. The scores are judgements based on the evidence and are open to challenge. They describe each Reform Objective in its fullest form, at the reshape end of the scale of change.

*Table A B.1. Scoring complexity*

| Criterion | 0 | 1 | 2 | 3 |
|---|---|---|---|---|
| **Breadth**<br>How many organisations and boards must agree | – | One or two | Three to five | Six or more, or bilateral agencies too |
| **Mandate**<br>What must change in either founding documents or board-approved roles | No change | Clarify or add a responsibility | Redefine roles | Create a new authority |
| **Financing flows**<br>What must change in how funders and organisations raise and channel money | No change | Adjust rules | Redirect or pool funding | Change policies, funding windows and cycles |
| **Organisation design**<br>What must change in structures and processes | No change | Adjust processes | Build a new shared function | Consolidate or merge |
| **Country role**<br>How far the work moves towards national systems | No change | Rely on national systems | Fully hand the process to national authorities/ partners | – |

**Note:** Reading the score: complexity is the sum of the five criteria (maximum 14). Low is 5 or under, moderate is 6 to 8, and high is 9 or over. The scores are judgements based on the evidence that are open to challenge.

### Table A B.2. Scoring benefit

| | Benefit for countries (0–5)<br>What changes for recipient governments. Each level includes the levels below. | | Benefit for the system (0–5)<br>What changes across global organisations. Each level includes the levels below. |
|---|---|---|---|
| 0 | **No observable change** | 0 | **No observable change** |
| 1 | **Minor convenience**<br>**How to check:** Simpler templates or reporting formats, fewer or joint missions, a shared calendar of partner visits, joint annual reviews | 1 | **Reforms within organisations**<br>**How to check:** Relevant organisation-specific reforms within two or more global organisations |
| 2 | **Fewer separate processes to manage and coordinate**<br>**How to check:** Fall in the number of applications, assessments or reports a set of 'tracer' governments have to manage | 2 | **Organisations rely on each other's work**<br>**How to check:** Several organisations accept each other's assessments, audits or approvals; one disbursement calendar; joint country missions |
| 3 | **More predictable or better-value support**<br>**How to check:** Long-term pooled commitments; one disbursement timetable; harmonised transition schedules; lower prices and more secure supply of health products | 3 | **One shared system replaces several**<br>**How to check:** One shared process, platform or data system; agreed priorities and roles for purchasing and market shaping |
| 4 | **Support through, and building, national institutions and systems**<br>**How to check:** Year-on-year rise in the share of external funding planned, budgeted and reported through national systems; long-term (10+ year) support for national institutions | 4 | **Money and governance aligned across the system**<br>**How to check:** Shared functions costed and financed; funding between organisations matched to agreed roles; a standing arrangement whose decisions organisations follow |
| 5 | **Durable national capacity and commitment**<br>**How to check:** National technical capacity to plan, regulate, buy and monitor; rising domestic resources and national financial commitment to health | 5 | **Harmonised, flexible funding and support to countries**<br>**How to check:** Major funders provide funding to countries through one harmonised, flexible framework aligned to national plans |

**Total benefit is the sum of the two scores (maximum 10): low 4 or under, moderate 5 or 6, high 7 or over. Scores are provisional.**

## Complexity and benefit of each Reform Objective

Scores by criterion, ordered from the most complex Reform Objective to the least complex. All scores are provisional judgements based on the evidence. Merged Reform Objectives (1 and 2) take the higher score on each criterion of their components.

### Table A B.3. Complexity and benefit scoring

| | Reform objective | Breadth | Mandate | Financing flows | Organisation design | Country role | COMPLEXITY | For countries | For the system | BENEFIT |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Consolidated external financing for health systems, including mutual recognition of assurance and audit | 3 | 1 | 3 | 2 | 2 | **11** | 4 | 5 | **9** |
| 10 | Shared detection, alert and response | 3 | 1 | 2 | 2 | 1 | **9** | 3 | 4 | **7** |
| 6 | Integrated market shaping across essential products | 3 | 2 | 2 | 2 | 0 | **9** | 3 | 3 | **6** |
| 5 | Harmonised co-financing and transition pathway | 3 | 0 | 2 | 1 | 2 | **8** | 4 | 3 | **7** |
| 9 | Joint financing for shared global functions | 3 | 1 | 3 | 1 | 0 | **8** | 3 | 4 | **7** |
| 7 | A standing arrangement to oversee roles and mandates | 3 | 3 | 0 | 2 | 0 | **8** | 1 | 4 | **5** |
| 2 | One country compact, binding on all partners, including benchmarks for the quality of external assistance | 3 | 0 | 1 | 1 | 2 | **7** | 4 | 3 | **7** |
| 4 | Longer financing horizons for national institutions | 2 | 0 | 2 | 1 | 2 | **7** | 5 | 1 | **6** |
| 8 | System-wide oversight of funding flows | 3 | 0 | 2 | 1 | 0 | **6** | 3 | 4 | **7** |
| 3 | A defined, complementary role for external support | 3 | 1 | 0 | 1 | 1 | **6** | 3 | 2 | **5** |

**Key:** Implication 1: Centred on countries; Implication 2: Shift financing behaviour and incentives; Implication 3: Govern the system as a whole; Implication 4: Deliver and finance global functions

**Complexity (0–14):** high 9 or over, moderate 6 to 8, low 5 or under.
**Benefit (0–10),** scored on the scales on the previous slide: high 7 or over, moderate 5 or 6, low 4 or under.

# Annex C. The flow from evidence to Reform Objectives

This annex brings together the evidence on which the Reform Objectives rest: the flow from the findings of Output 2 to the Reform Objectives, where each organisation is best placed, and the strengths and gaps of the nine organisations for each function.

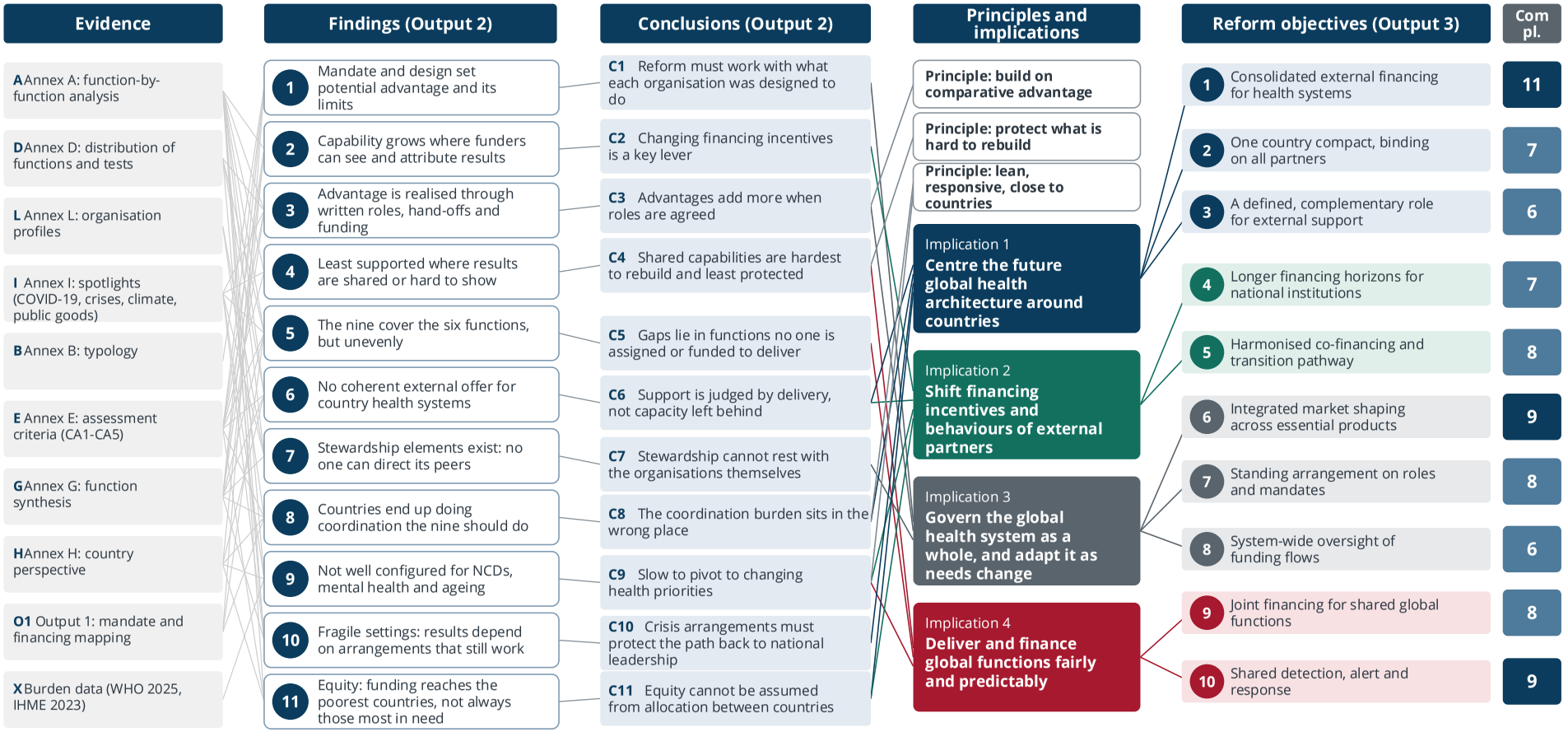
The following table presents each conclusion of Output 2, with the evidence and findings behind it, and what it leads to in Output 3. Evidence codes refer to the Output 2 annexes. The figure on the following page shows the same trail as a flow.

### Table A C.1. The flow from evidence to Reform Objectives

| Evidence | Findings | Conclusion (Output 2) | Leads to | Reform objectives (complexity) |
|---|---|---|---|---|
| **B, E, G, O1** | **F1** Design sets potential and limits | **C1 Reform must work with what each organisation was designed to do** | **Implication 3:** Govern and adapt | 6 Market shaping **(9)** · 7 Standing arrangement **(8)**<br>8 Funding flows **(6)** |
| **A, E, G, H** | **F2** Capability follows attributable results | **C2 Changing financing incentives is a key lever** | **Implication 2:** Shift financing incentives | 4 Longer horizons **(7)** · 5 Transition **(8)** |
| **A, D, E, G, I** | **F3** Written roles and hand-offs work | **C3 Advantages add more when roles are agreed** | **Principle: build on advantage**<br>**Implication 3:** Govern and adapt | 6 Market shaping **(9)** · 7 Standing arrangement **(8)**<br>8 Funding flows **(6)** |
| **A, E, I** | **F4** Shared or preventive results least supported | **C4 Shared capabilities are hardest to rebuild and least protected** | **Principle: protect what is hard to rebuild**<br>**Implication 4:** Deliver and finance global functions | 9 Joint financing **(8)** · 10 Detection and response **(9)** |
| **A, D, E, G, I, O1** | **F5** Functions covered, but unevenly | **C5 Gaps lie in functions no one is assigned or funded to deliver** | **Implication 4:** Deliver and finance global functions | 9 Joint financing **(8)** · 10 Detection and response **(9)** |
| **A, D, E, G, H** | **F6** No coherent offer for country systems | **C6 Support is judged by delivery, not capacity left behind** | **Implication 1:** Countries at the centre<br>**Implication 2:** Shift financing incentives | 1 Financing **(11)** · 2 Compact **(7)** · 3 Role of support **(6)**<br>4 Longer horizons **(7)** · 5 Transition **(8)** |
| **A, G, I, L** | **F7** No one can direct its peers | **C7 Stewardship cannot rest with the organisations themselves** | **Implication 3:** Govern and adapt | 6 Market shaping **(9)** · 7 Standing arrangement **(8)**<br>8 Funding flows **(6)** |
| **E, G, H, L, O1** | **F8** Countries do the coordinating | **C8 The coordination burden sits in the wrong place** | **Implication 1:** Countries at the centre<br>**Principle: close to countries** | 1 Financing **(11)** · 2 Compact **(7)** · 3 Role of support **(6)** |
| **A, H, I, X** | **F9** Slow to adapt to new health needs | **C9 Slow to pivot to changing health priorities** | **Implication 2:** Shift financing incentives<br>**Implication 4:** Deliver and finance global functions<br>**Principle: responsive** | 4 Longer horizons **(7)** · 5 Transition **(8)**<br>9 Joint financing **(8)** · 10 Detection and response **(9)** |
| **A, D, G, I** | **F10** Fragile settings depend on workarounds | **C10 Crisis arrangements must protect the path back to national leadership** | **Implication 1:** Countries at the centre | 1 Financing **(11)** · 2 Compact **(7)** · 3 Role of support **(6)** |
| **A, E, H** | **F11** Most in need not reliably reached | **C11 Equity cannot be assumed from allocation between countries** | **Implication 1:** Countries at the centre<br>**Implication 2:** Shift financing incentives | 1 Financing **(11)** · 2 Compact **(7)** · 3 Role of support **(6)**<br>4 Longer horizons **(7)** · 5 Transition **(8)** |

**Evidence:** A Annex A function analysis B Annex B typology D Annex D distribution and tests E Annex E criteria G Annex G function synthesis H Annex H country perspective I Annex I spotlights L Annex L organisation profiles O1 Output 1 X Burden data (WHO, IHME)
**Complexity (0-14):** high 9 or over, moderate 6 to 8, low 5 or under. Scores from Annex B, provisional.

## Figure A C.1. The flow from evidence to Reform Objectives





www.mopan.org

Secretariat@mopan.org



MOPAN

© MOPAN 2026



MOPAN