REIMAGINING GLOBAL HEALTH REFORM IN THE ASIA PACIFIC: Nationally Designed, Regionally Coordinated, and Globally Aligned

FINAL REPORT

PMAC | STRATEGIC INSTITUTE

iHPP FOUNDATION

NUS National University of Singapore | Saw Swee Hock School of Public Health

清華大學 Tsinghua University

This document and its contents are prepared from the Asia Pacific Regional Dialogue on Global Health Reform

FOREWORD BY THE STRATEGIC COUNCIL

Asia Pacific is arguably the most complex of Wellcome's five regional dialogues. Our region spans an extraordinary mix of political systems and health systems: from large federal democracies to small island nations, from advanced universal health coverage to systems still navigating foundational reforms. The region also hosts a number of global health platforms with unique governance mechanisms. This diversity, despite challenging, offers greatest opportunities to draw lessons. Despite very different political traditions and health systems, representatives from sub-regions such as South Asia, Southeast Asia, East Asia, and Oceania were able to agree on several meaningful priorities, proving that even in a region as varied as ours, shared goals can take shape.

Convened by the PMAC Consortium – Thailand's International Health Policy Program Foundation, Singapore's Saw Swee Hock School of Public Health at the National University of Singapore, and China's Tsinghua Vanke School of Public Health – this Dialogue was steered entirely by young emerging global health leaders from these institutions, signalling an important shift toward empowering the voices of future leaders.

The Dialogue brought together former health ministers, senior policymakers, WHO representatives, regional and domestic financiers, civil society, academia, the private sector, UN agencies, development banks and key development partners, staying true to the commitment to multisectoral participation in shaping global public health.

Asia Pacific has everything it needs to define the next chapter of global health: talent, technology, and funders like JICA and the Asian Development Bank who are committed to long-term and sustainable progress. As part of the PMAC Consortium, this Dialogue is more than just a meeting, it is a collective step toward shaping the world we want.

Now is the time for us to understand our shared health priorities in Asia Pacific, build on our collective insights, and work side-by-side with confidence and trust to create a fairer, healthier, and more sustainable future for all.

***Margaret Chan**, Vanke School of Public Health, Tsinghua University*

***Soumya Swaminathan**, M S Swaminathan Research Foundation*

***Viroj Tangcharoensathien**, International Health Policy Program Foundation*

***Yik Ying Teo**, Saw Swee Hock School of Public Health, National University of Singapore*

***Suwit Wibulpolprasert**, Prince Mahidol Award Conference Strategic Institute*

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List of Abbreviations

ADB	Asian Development Bank
AP-GHRC	Asia Pacific Global Health Reform Coalition
APEC	Asia-Pacific Economic Cooperation
ASEAN	Association of Southeast Asian Nations
CSO	Civil Society Organization(s)
FGD	Focus Group Discussion(s)
Gavi	Global Vaccine Alliance
GCF	Green Climate Fund
JEE	Joint External Evaluation
KII	Key Informant Interview(s)
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organization(s)
ODA	Official Development Assistance
PIANGO	Pacific Islands Association of Non-Governmental Organisations
PIFS	Pacific Islands Forum Secretariat
SDG	Sustainable Development Goals
SPC	Pacific Community
UN	United Nations
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WPRO	Western Pacific Regional Office (WHO)

Executive Summary

The Asia Pacific Dialogue on Global Health Reform brought together diverse stakeholders across 25 countries in a four-month consultation process to define the region's vision for global health architecture. Commissioned by the Wellcome Trust as part of a series of five regional dialogues on global health reform, the Dialogue engaged governments, multilateral organizations, civil society, academia, philanthropy, and the private sector through evidence review, stakeholder mapping, interviews, a regional survey, focus groups, and a modified Delphi convening in Singapore. The result is a coordinated set of recommendations for a global health architecture designed nationally, coordinated regionally, and aligned globally.

While the normative and collaborative functions of current architecture are valid, they remain constrained in practice, and other functions do not well serve the needs and priorities of the Asia Pacific region. Decision-making power remains dominated by high-income countries. Aids effectiveness failed, as reflected in donor-driven priorities that distorted national health agendas and perpetuated dependency. Accountability mechanisms are asymmetric, tracking recipient performance while donors face minimal scrutiny. Fragmented financing creates duplication and administrative burden. At the national level, weak priority-setting processes and corruption undermine the legitimacy of health investments. These failures are not incidental; they reflect fundamental design flaws in an architecture built for a different era.

Based on extensive consultation with stakeholders across the region, the Dialogue proposes six integrated reforms addressing governance and financing. Governance reforms seek to establish national multisectoral platforms for evidence-based priority-setting that include marginalized voices; create effective monitoring and evaluation systems holding donors, governments, and implementers accountable to communities; and build dedicated regional coordination platforms with clear mandates to harmonize efforts and amplify collective voice. Financing reforms coordinate fragmented multi-donor investments in global and regional public goods; align financing mechanisms with nationally determined priorities through equitable participation of recipient countries in governance; and support transition from donor dependence to sustainable domestic investment through increased fiscal space for health, technical capacity-building, and transition planning.

Three practical pathways translate this reform vision into action: institutionalizing national coordination platforms and financing transitions within existing government structures; establishing sub-regional data repositories and coordination mechanisms organized around donor, technical, and community streams; building a regional governance mechanism through the proposed Asia Pacific Global Health Reform Coalition and digital knowledge exchange.

Global health reform in the Asia Pacific towards nationally designed, regionally coordinated, and globally aligned architecture goes beyond technical recommendations. It is a testament to regional voices shaping regional consensus, to diverse stakeholders building a shared vision, and to the Asia Pacific region claiming agency in global health reform rather than reacting to agendas set elsewhere.

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I. Introduction

Commissioned by the Wellcome Trust as part of a series of five regional dialogues on global health reform, this initiative had three objectives: identify shared regional priorities for architecture functions and forms; distil principles reflecting what must change; and chart feasible reform pathways across global, regional, sub-regional, and national levels. The Dialogue deliberately convened diverse actors, governments, multilateral organizations, regional platforms, academia, civil society, philanthropy, and the private sector, to ensure representative and actionable perspectives. Partners across the Asia Pacific engaged in a four-month consultation process that combined evidence review, stakeholder mapping, interviews, a regional survey, focus groups, and a modified Delphi. The Dialogue proposed a global health architecture that is nationally designed, regionally coordinated, and globally aligned—with Asia Pacific shaping rather than reacting to reform. In this report, we present insights from the Dialogue in four parts: (1) a stock-take of the current global health architecture; (2) a set of governance and financing proposals for reform; (3) a set of integrated reform pathways; and (4) next steps for sustaining momentum.

II. Methods

The Dialogue employed a two-phase approach to engage diverse stakeholders across 25 Asia Pacific countries in developing a collective position on global health reform. Together, Phase I (August–October 2025) and Phase II (November 2025) involved the following activities:

1. **Rapid literature review:** To understand the current global health architecture, including existing governance and financing mechanisms, challenges and opportunities for reform.
2. **Systematic stakeholder mapping:** To identify participants for project activities.
3. **Key informant interviews (KIIs):** To gather in-depth insights from diverse stakeholders on global health reform proposals and pathways.
4. **Focus group discussions (FGDs):** To facilitate dialogue among key stakeholder groups and elicit early areas of convergence and divergence.
5. **Online survey:** To capture views across Asia Pacific on current challenges in the global health architecture, and potential reform proposals and pathways.
6. **Convening:** Three-day in-person convening held in Singapore to facilitate consensus-building utilizing a modified Delphi process.

Table 1: Characteristics of participants across all Dialogue activities

Characteristics	KIIs and FGDs	Online Survey	Convening
Sub-region			
- South Asia	12 (27%)	39 (18%)	12 (23%)
- Southeast Asia	15 (33%)	81 (36%)	24 (46%)
- East Asia	9 (20%)	19 (9%)	10 (19%)
- Pacific	8 (18%)	25 (11%)	6 (12%)
- Other	1 (2%)	58 (26%)	0 (0%)
Stakeholder Type			
- Government or multilateral	20 (44%)	32 (14%)	23 (44%)

Characteristics	KIIs and FGDs	Online Survey	Convening
- Research or academia	12 (27%)	93 (42%)	11 (21%)
- For-profit sector	1 (2%)	24 (11%)	2 (4%)
- Non-profit[1] or civil society	12 (27%)	73 (33%)	16 (31%)
Total	45	222	52

[1] *Includes development partners and philanthropies.*

III. The Architecture Today: What Works and Does Not Work for Asia Pacific

The Dialogue highlighted the following strengths of the current global health architecture:

1. **WHO's role as a normative body**: Participants recognized the need for a single global body that has the authority and legitimacy to establish technical guidance and standards. Participants found WHO's normative function to be an asset to the current architecture and generally supported its continued role.
2. **Transnational collaboration and cross-learning:** Global and regional health institutions have successfully created collaborations untethered from individual national government interests, leading to platforms for cross-learning and knowledge sharing. This transnational function allows smaller or less-resourced countries to benefit from global expertise and standards that would be difficult to develop independently.
3. **Multi-stakeholder partnerships and blended finance models**: Participants emphasized that multi-stakeholder partnerships bringing together philanthropy, the private sector, and commercial capital have created valuable spaces for innovation in health financing. Blended finance models, where philanthropy de-risks investments to attract larger-scale private funding, have demonstrated effectiveness in building evidence required for government buy-in and securing subsequent transition into public financing.
4. **Collaborative pooled funding models**: Participants noted that pooled funding mechanisms, such as the Global Fund, have successfully enabled participation from multi-stakeholder actors at levels they find comfortable, bringing in non-government actors into strategic cross-regional initiatives who would not otherwise participate.
5. **Health is increasingly recognised as a collective priority**: at global, regional, and national levels, it has been elevated in political agendas, accompanied by sustained commitments to address key health challenges. This prioritisation is evident in its placement of health among the top priorities in national election campaigns and political manifestos and in the continued resource allocation to the health sector over the years, from public budgets and philanthropic actors, despite broader fiscal constraints. Together, these trends suggest that health continues to hold a prominent position in policymaking and resource mobilisation, emphasizing its role as a shared and enduring priority.

Conversely, the Dialogue highlighted the following weaknesses of the current global health architecture:

1. **Global North-led decision-making:** Decision-making power, resources, and technical capacities remain concentrated in high-income countries. This shapes Global South countries' health agendas as reflected in funding decisions, technical assistance, and capacity-building initiatives—reinforcing power asymmetries and constraining country ownership.
2. **Donor-driven priorities:** Donor-driven funding mechanisms can undermine national

health priorities, increase administrative burdens, and duplicate technical work across multiple initiatives. Countries' reliance on official development assistance (ODA) and other donor grants results in donor-dominated narratives and funding patterns that reinforce dependency and hinder the development of sustainable domestic health financing. It exacerbates alignment gaps between national health and donor-driven agendas.

3. **Unclear division of responsibilities**: Overlapping mandates among global health actors, for example, between WHO headquarters, regional offices, and country offices, leads to duplication and insufficient responsiveness to country priorities. The mandates of regional bodies such as the Pacific Community (SPC) and the Association of Southeast Asian Nations (ASEAN) are not sufficiently developed to drive regional health agendas or represent regional priorities effectively.
4. **Weak accountability mechanisms:** The absence of accountability mechanisms undermines trust between funding countries, recipient nations, and implementing agencies. The current system lacks effective ways to verify that commitments translate into action, resources are spent as intended, and progress is measured transparently. This accountability gap reinforces power imbalances. Donor countries and multilateral funders face minimal scrutiny over whether they deliver promised funding, meet deadlines, or align with recipient priorities. Meanwhile, recipient countries bear heavy reporting requirements to donors. The result is a trust deficit between donor and recipient nations, among recipient countries competing for limited resources, and across multilateral organizations meant to coordinate global health efforts.
5. **National level constraints:** At the national level, short-term populist decision-making and corruption-related leakages undermine the efficiency and sustainability of health investments by eroding the credibility and legitimacy of the priority-setting process. The absence of independent evaluation compounds these challenges.

IV. Proposals to Reform the Global Health Architecture

The Dialogue revealed that effective reform requires both innovation and optimization. While some proposals introduce new mechanisms, the majority strengthen existing structures that are valuable but remain under-resourced, under-mandated, or poorly coordinated. This pragmatic approach reflects regional priorities: strengthen what works, fix what's broken, and build new capacity only where gaps are evident. This section synthesises the functions, forms, and enablers[1] prioritised during the Dialogue. Reform proposals are intended as integrated packages, operationalized through three reform pathways outlined in Section V.

A. Governance Reform Proposals (G1-3)

Three governance reforms address the misalignment in priority-setting processes, accountability gaps between donors and recipients, and the need for stronger inter-level coordination through greater investment in regional and sub-regional collaboration.

G1. Make Priority-Setting Evidence-Based, Multi-Sectoral, and Community-Driven

Short-term populist decision-making and corruption compromise both the credibility (evidence-based) and legitimacy (broad support) of health investments in the Asia Pacific.

- **Function:** Enable countries to set health priorities that are nationally relevant and regionally coordinated as common regional health priorities. Priorities should be credible and legitimate, based on scientific evidence with meaningful participation from

[1] Function i.e., what the reform should do. Form i.e., the way the reform should be structured. Enabler i.e., condition, resource, capability, or political factor that allows the form to function effectively.

government, civil society, private sector, and communities, including youth, indigenous peoples, people with disabilities, and other groups facing health inequities.

- **Form:** National and/or sub-regional platforms that convene health and non-health sectors (e.g., finance, environment) and structure inclusive participation from government, private industry, academia, and civil society to identify national health priorities, which feed into common regional health priorities (Box 1).
- **Enabler 1: Strong political and technical leadership at national and regional levels.** This requires identifying and cultivating global health champions, including political leaders and technical experts, particularly from low- and middle-income countries and small island states, to confidently articulate and advocate for their priorities at regional and international forums, thereby rebalancing power dynamics.
- **Enabler 2: Regional and sub-regional knowledge hubs** to collect evidence on best practices for cross-sectoral and cross-country learning, supported either through existing global organisations such as the WHO, Global Fund, or World Bank, regional organizations such as ADB, ASEAN, and SPC, or academic institutions.
- **Enabler 3: Formal participation mechanisms for marginalized actors.** Many marginalized actors are underrepresented in decision-making spaces, undermining the credibility of priority-setting processes. Governance structures must incorporate concrete and formal mechanisms for civil society participation to remove ambiguity and prevent tokenistic engagement, by clearly prescribing a role for civil society, providing a continuous consultation process and procedures, and establishing transparent feedback loops to assess whether civil society's voices are being duly heard and considered.

Box 1: Example of an inclusive governance model

Thailand's National Health Assembly convenes 300+ participants annually from government, academia, civil society, and the private sector to set health priorities through structured dialogue. Any citizen can propose agenda items. The Assembly produces policy resolutions—on topics from tobacco control to migrant health—that carry legal weight when submitted to the National Health Commission and cabinet. Since 2008, it has demonstrated how institutionalized multisectoral platforms can make priority-setting both evidence-based and broadly legitimate. Such a mechanism can be applied to sub-regional/regional platforms to identify common regional health challenges.

G2. Establish National and Regional M&E Systems that Hold All Actors Accountable

Current monitoring and evaluation systems primarily track recipient country performance against donor targets. There are no equivalent systems to track donor performance against country targets. Asymmetric accountability perpetuates power imbalances.

- **Function:** Hold actors accountable to their global health commitments, ensuring that commitments translate into action, that resources are used appropriately, that progress is measured and communicated transparently, and that progress serves communities.
- **Form**: Parallel monitoring and evaluation mechanisms with clearly defined indicators that are anchored in equity. A combination of self-assessment, peer review, and independent external evaluation that meaningfully engages the community should be used (see Box 2). Accountability mechanisms must be embedded within priority-setting platforms (see G1) to enable consistent oversight and shared learning from the outset.
- **Enabler 1: A multi-stakeholder, multi-sectoral regional reform task force** composed of identified champions would provide the operational structure to steer the regional reform agenda, develop a regional collaboration framework, and monitor its implementation.

Box 2: Parallel compliance mechanism involving multi-stakeholder and multisectoral participation

The Healthy Islands Monitoring Framework offers a strong model for the Pacific, with clearly defined mandatory indicators, accountability matrices, defined roles and responsibilities, and an external review process led by SPC and WHO. However, while it provides structured technical and political oversight, it does not yet incorporate participatory accountability: communities, civil society, and marginalised groups are not formally embedded in the review process.

The UN Economic and Social Commission for Asia and the Pacific (UNESCAP) has explored participatory accountability mechanisms for the SDGs—such as peer review and independent review—which, while not health-specific, can serve as a valuable model for global health governance.

The joint external evaluation process under the International Health Regulations is a model of voluntary external evaluation of health security capabilities, in addition to self-reporting, but it lacks an independent external assessment (e.g., an independent compliance committee or formal civil society participation). This strengthened model can be extended to other health areas, such as health system strengthening, to ensure countries and donors deliver on commitments that matter for communities.

G3. Differentiate Institutional Mandates to Enhance Regional Governance

Unclear division of responsibilities between levels creates overlap. Regionalization coupled with explicit mandate reform can clarify functions at each level. Global health institutions issue technical guidance and standards for global public goods (such as International Health Regulations); global financial institutions coordinate financial flows from diverse actors and sectors; regional institutions establish shared needs and priorities, define regional public goods, mobilize financial and technical resources, and oversee country-level accountability.

- **Function:** Identify shared priorities among countries (G1), coordinate agenda-setting at regional and sub-regional levels and foster regional and sub-regional collaborations accordingly. This includes generating shared priorities as identified by countries, harmonizing efforts across stakeholders, and mobilizing collective resources, including political will, technical expertise, and financial resources.
- **Form:** Regional and sub-regional platforms dedicated to multilateral and multistakeholder dialogue and coordinated collaboration. The platform(s) should integrate closely with global mechanisms while remaining responsive to countries' needs (Box 3).
- **Enabler 1: Explicit mandate reform** to provide the necessary authority and legitimacy for regional institutions to coordinate effectively without duplicating global or national efforts. Mandate reform should re-focus institutions on their primary roles where they have a comparative advantage, minimising overlap with other institutions at other levels. Organisational committees such as the WHO Executive Board, or independent councils such as The Elders, could oversee reforms. Mandate reform should encompass UN agencies, international financial institutions, regional blocs, NGOs, and private actors.
- **Enabler 2: Regional health strategies** formally endorsed by countries and embedded within organisational mandates give regional coordination platforms the policy foundation to operate effectively. Existing models, such as the Pacific Roadmap for Sustainable Development and the renewed 2025 Healthy Islands Framework, demonstrate how sub-regional mechanisms can anchor cross-sector collaboration.

Box 3: Asia Pacific Global Health Reform Coalition

The proposed Asia Pacific Global Health Reform Coalition (outlined in detail in Section V) would convene diverse stakeholders, facilitate evidence sharing, support policy coherence, and provide a structured space where community-level realities inform sub-regional and regional agendas, and ultimately shape global decision-making. This could be an expansion of the existing Asia Pacific Parliamentarian Forum on Global Health, which is limited to parliamentarians of the WHO WPRO and ASEAN member states, but serves as a platform to exchange ideas, build political will, strengthen capacity, and foster collaboration at the regional level through a whole-of-government approach.

B. Financing Reform Proposals (F1-3)

Three financing reforms address coordination failures at the global level, power imbalances in financing governance, and the urgent need to transition toward sustainable domestic investment. These proposals are designed to work in concert with the governance reforms.

F1. Support Responsible Transition from Donor Dependence to Sustainable Domestic Financing

While some Asia Pacific countries remain reliant on ODA, donor grants, and out-of-pocket expenditures, many have transitioned to domestic financing. Despite this shift, health remains under-prioritized in national budgets, hindering the development of sustainable domestic health financing. The current architecture lacks explicit mechanisms to build domestic capacity and plan for a responsible transition from external financing.

- **Function:** Support countries' transition toward stronger domestic investment in health through explicit transition planning, domestic capacity strengthening, and diversified financing mechanisms that reduce dependence on a handful of resource-rich donors.
- **Form:** Conditional financing that requires explicit transition, exit, and sunset plans, including dedicated support for increased fiscal space for health and building domestic technical and institutional capacity. Financing would target horizontal, systems-level functions, including Health Technology Assessment, National Regulatory Authorities, national procurement systems, evaluation mechanisms, and digital data frameworks.
- **Enabler 1: Robust resource mapping and expenditure-tracking mechanisms.** National and regional systems that accurately and dynamically track allocation and disbursement of financial resources across all sources (government, private, philanthropy, ODA). These mechanisms improve coordination, reduce fragmentation, safeguard from corruption and misuse, and enable evidence-based planning for resource mobilization.
- **Enabler 2: Increased private sector participation with accountability safeguards.** Better integration of the private sector into the governance and financing architecture to unlock additional funding for national systems and regional public goods. This requires frameworks that increase private-sector participation without disproportionately increasing their influence, ensuring responsible and sustainable financing.
- **Enabler 3: Mechanisms for blended finance and innovative financing.** Policy-based lending, blended finance models, and innovative mechanisms (such as health impact bonds or regional pooled procurement) that reinforce national capacity, de-risk domestic investment, and attract diverse funding sources while maintaining country ownership.

F2. Align Financing Mechanisms with Nationally-Determined Priorities

Donor-driven priorities distort national health agendas, increase administrative burdens, and perpetuate dependency over partnership. Current financing architecture gives recipient countries minimal voice in designing the mechanisms that shape their systems.

- **Function:** Ensure that financing flows respond to and are accountable to nationally determined health priorities, with meaningful participation of recipient countries in conceiving, designing, and governing global health financing mechanisms.
- **Form:** Regular nationally led priority-setting exercises, aligned with platforms described in G1, that explicitly guide country-level financing decisions. These national priorities would inform financing allocation at sub-regional and regional levels, creating an upward flow of country-determined needs rather than top-down donor agendas.
- **Enabler 1: Equitable participation of recipients in the governance of the financing mechanism.** Meaningful engagement of low- and middle-income countries in decision-making processes for global pooled financing mechanisms, including design, resource allocation, and performance monitoring. Countries should have voting power proportional to their stake in outcomes, not just financial contributions.
- **Enabler 2: Financing support for national priority-setting processes.** Dedicated funding to establish and sustain the multisectoral national platforms and cultivation of global health champions described in G1, ensuring these exercises are adequately resourced and occur regularly to guide financing decisions.

F3. Coordinate Fragmented Financing for Global and Regional Public Goods

Donor-driven funding mechanisms result in fragmented investments, duplication of efforts, and insufficient coordination across multiple funding streams. This undermines efficiency and prevents adequate financing of critical global and regional public goods.

- **Function:** Coordinate, harmonize, and synergize funding strategies and investments across multilateral development banks, bilateral donors, philanthropies, and private sector actors that support global and regional public goods. At the regional level, designated institutions (such as regional development banks or academic institutions) can conduct routine multi-sectoral resource mapping tied to regional health strategies.
- **Form:** Clear coordination mechanisms that separate financing functions from implementation and priority-setting functions.
- **Enabler 1: Explicit mandate reform** for global and regional financial institutions. Clear, transparent mandates to coordinate financing without duplicating implementation roles. This requires engagement with governance bodies, including the IMF, World Bank, and regional development banks, to formalize coordination strategies.
- **Enabler 2: Regional resource mapping and expenditure-tracking mechanisms (F1).** All financial actors should be required to comply with reporting requirements.

V. Identified Reform Pathways

Whilst Section IV articulates what the future global health architecture should achieve through six reform proposals, this section presents practical pathways to get there, informed by participants' interventions during the Dialogue. Given the weaknesses in the current global health architecture outlined in Section III, the pathways focus on the national, sub-regional, and regional levels. This is intentional to drive a reform process from the ground up, reflecting a defining characteristic of the Asia Pacific vision: reform should be designed nationally, coordinated regionally, and aligned globally. Hence, the bulk of implementation occurs at national, sub-regional, and regional levels, with the global level playing a supporting rather than determining role. The proposed inversion of traditional power dynamics is deliberate. Countries first define priorities and build domestic capacity. Sub-regional mechanisms coordinate shared challenges and resources second. Regional platforms harmonize efforts and amplify the collective voice. The three pathways work in concert. Each pathway addresses

multiple reform proposals simultaneously, recognizing that governance and financing reforms are deeply interconnected (Figure 1).

A. National Coordination Platforms for Priority-Setting & Financing Transition

Reform begins at the country level. Participants identified the need to institutionalize inclusive national coordination platforms that bring together government agencies across sectors (health, finance, environment) and stakeholders (private sector, civil society, and marginalized groups). These platforms operationalize evidence-based, multi-sectoral priority-setting (G1) and accountable M&E at the national level (G2), while ensuring that financing flows align with nationally determined priorities (F2) and support the transition toward domestic investment (F3). National coordination platforms would serve 4 functions: 1) develop National Health Investment and Transition Plans mapping current resources and charting pathways toward domestic financing; 2) define cross-sector priorities recognizing health's interconnections with climate and economic development; 3) map existing and potential domestic financing sources to improve transparency; and 4) feed priorities upward to ensure sub-regional and/or regional coordination reflects country-defined needs.

- **Implementation:** Countries would embed these functions within existing Health Sector Coordination Committees rather than creating parallel structures, expanding mandates to include finance ministries, climate sectors, and marginalized groups currently excluded.
- **Timeline:** 1-2 years to institutionalize platforms and begin developing Investment Plans.
- **Key risks:** Continued reliance on ODA or out-of-pocket expenditure; corruption and resource leakages; changes in political leadership and priorities; silos and competition between sectors; lack of synergy across institutional mandates; and workforce shortages.
- **Mitigation:** Institutionalize key functions within stable governance structures.

B. Sub-regional Coordination and Accountability Mechanisms

Key sub-regional functions can address accountability gaps (G2 and F2), coordinate fragmented priorities and financing (G3 and F1), and enable transition planning through resource mapping (F3). Sub-regional data repositories would support evidence-based national priority-setting by providing comparable data on health financing, program performance, and outcomes. An **ASEAN Health Data Repository**, for example, could enable Southeast Asian countries to benchmark health system investments and identify best practices in sustainable financing models. Repositories would be country-owned, with sub-regional hosting facilitated by national multistakeholder forums, thereby distributing the administrative burden and reinforcing the role of sub-regional coordination in serving national priorities.

Sub-regional coordination mechanisms could operate through three streams. The **donor/partner stream** (led by ADB, World Bank, DFAT, MFAT, JICA, GCF) would consolidate development assistance priorities, create resource-mapping and partner-coordination matrices, and facilitate investment dialogues—directly addressing financing fragmentation. The **technical stream** (anchored by WHO WPRO, SPC, UN agencies, academia) would facilitate cross-country learning platforms and maintain performance dashboards for accountability. The **community engagement stream** (PIANGO and regional NGO networks) would ensure that civil society voices shape coordination priorities and hold actors accountable. Streams could be coordinated at a regional level, for example, by the Asia Pacific Global Health Reform Coalition proposed in the regional pathway below; or by sub-regional frameworks and mechanisms, such as a Pacific Health Financing Compact proposed by

participants from the Pacific sub-region, which would integrate domestic co-financing, regional pooled procurement, and transition roadmaps in line with financing reforms (F3).

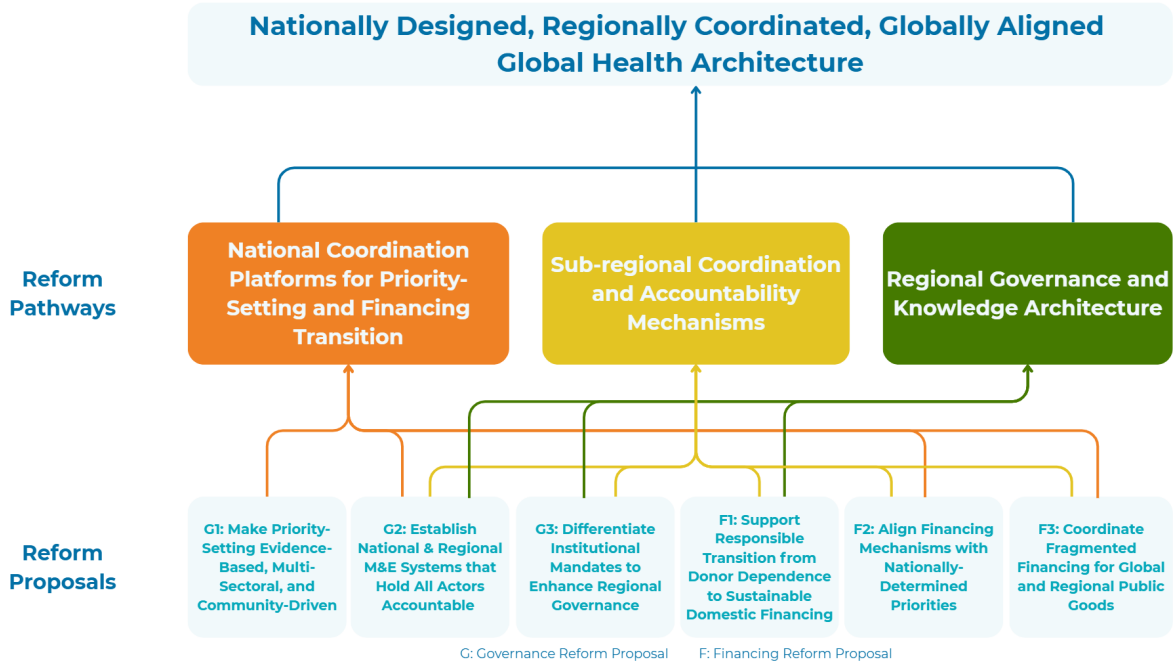
- **Implementation:** Pragmatic use of existing institutions; for example, the Pacific sub-region propose formalizing Melanesia, Polynesia, and Micronesia health groupings under the SPC/WPRO umbrella over 2-3 years and conducting joint donor mapping.
- **Timeline**: Data repositories operational by 2030, coordination streams within 2-3 years.
- **Key risks:** Funder-driven agendas could undermine ownership; lack of political support could leave mechanisms under-resourced; data quality issues could undermine credibility.
- **Mitigation:** Integrate resource mapping into existing monitoring cycles, such as the Healthy Islands Framework, to strengthen rather than duplicate current institutions.

C. Regional Governance and Knowledge Architecture

Regional coordination (G3) requires dedicated infrastructure that harmonizes efforts, mobilizes collective resources, and ensures national needs are channelled upward into global forums. The Dialogue proposed four interconnected components that also strengthen regional accountability (G2) and coordinate financing (F1). The **Asia Pacific Global Health Reform Coalition** (see Box 3) would provide a multi-stakeholder convening platform to co-develop priority reform areas, accountability indicators, and pilot actions. Led by academia with participation from governments, WHO regional offices, ADB, ASEAN, multilaterals (UNFPA, UNICEF), civil society, private sector, and donors, the Coalition creates space for diverse actors to shape regional agendas. A **Regional Reform Taskforce or Secretariat** would provide operational structure to develop and monitor a regional collaboration framework, ensure inclusive participation of marginalized stakeholders, and coordinate financing among different donors. The **Asia Health Exchange**, a digital platform, would operationalize continuous alignment through knowledge sharing, capacity building, resource mapping, and expenditure tracking (F1), and strategic partnerships to strengthen domestic investment.

- **Implementation:** An initial convening to soft launch the regional architecture, followed by an extended period for political mobilization before operationalization. The phased approach recognizes that building buy-in and establishing the appropriate mechanisms takes time.
- **Key risks:** Fragmentation across sub-regions; vested stakeholder interests and resistance to cooperation; insufficient financing; and a lack of perceived legitimacy or credibility among specific stakeholders (e.g., academia).
- **Mitigation:** Diversified funding across philanthropy, development banks, and in-kind academic support; blending climate and health funding to address fiscal constraints; robust monitoring and evaluation mechanisms to track the value-add of all partners.

Figure 1 Asia Pacific Reform Proposals and Pathways



VI. Proposed Next Steps

The immediate priority is to maintain momentum from the Singapore convening and translate consensus into action. The Dialogue identified the following opportunities in 2026 and beyond:

1. **PMAC 2026 special session.** A dedicated session at the Prince Mahidol Award Conference (PMAC) 2026 will present the regional position to a broader global health audience. PMAC can offer visibility and legitimacy, accelerating buy-in from stakeholders and positioning the Asia Pacific perspective within wider global reform conversations.
2. **Organic momentum from convening relationships.** The relationships and commitments formed during the convening represent the Dialogue's most valuable output. Participants return with a shared understanding of regional priorities and connections to potential partners across sectors and sub-regions. The hope is that these interactions catalyze change through bilateral collaborations, sub-regional initiatives, and institutional innovations, without requiring centralized or formal mechanisms in the near term.
3. **Strategic touchpoints throughout 2026.** Strategic touchpoints throughout 2026 can surface emerging initiatives, share early implementation lessons, facilitate connections between actors pursuing complementary reforms, and sustain collective commitment. Opportunities include the UHC High-level Forum 2025, Global Health Security Conference 2026, WHS Regional Meeting 2026, and HSR2026 Global Symposium on Health Systems Research. These touchpoints need not be elaborate; their purpose is to keep the Dialogue alive and visible, rather than allowing momentum to dissipate.
4. **Building regional capacity for priority setting and accountability in 2026**. To move from consensus to implementation, several concrete initiatives can be launched in 2026. The first step is to establish an Asia Pacific (or sub-regional) team of technical experts skilled in health priority setting. This expert network would support national governments and sub-regional coalitions (ASEAN, SPC, SAARC) in identifying national health priorities and regional public goods. In parallel, a regional financing roundtable should convene funders, donors, and development banks to discuss financing strategies aligned with

identified priorities, including innovative approaches to funding regional public goods. Finally, a parallel network of M&E and accountability experts should be established to strengthen domestic capacity for policy and program evaluation.

5. **Looking beyond 2026.** The reform proposals and pathways outlined in Sections IV and V represent medium- and longer-term ambitions that should emerge from demonstrated need rather than being imposed. Early pilots of national coordination platforms, sub-regional donor mapping, and knowledge exchange activities can help to assess feasibility.

VII. Concluding Remarks

The Asia Pacific Dialogue presents an alternative architecture grounded in subsidiarity, inclusivity, and national and regional ownership. The Dialogue constructs proposals and pathways to reform around country-defined priorities, and only then considers how global institutions should align. The reforms are ambitious in vision—regionalized governance, inclusive collaboration, domestically-driven financing, and institutionalized accountability—but pragmatic in implementation: building on existing institutions, embedding reforms within established structures, and acknowledging the need to adapt to diverse contexts. The Dialogue revealed significant consensus on core principles, even as it generated diverse implementation pathways at national, sub-regional, and regional levels. This report represents the collective wisdom of diverse stakeholders across 25 Asia Pacific countries, ushering in reform that is designed nationally, coordinated regionally, and aligned globally.

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