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CASE STUDY

GLOBAL PUBLIC HEALTH AS A GLOBAL PUBLIC GOOD

CLUB DE MADRID

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EXECUTIVE SUMMARY

Global public health is a global public good because its benefits extend beyond borders; no country can fully secure it alone, and failures in one setting can rapidly spread risks elsewhere. Yet global public health is not delivered in the abstract. It is produced through concrete functions - surveillance, prevention and preparedness, health workforce capacity, regulatory standards, medical countermeasures, essential service delivery, trusted data systems, and financing arrangements - that must operate across national, regional, and global levels. The core challenge, therefore, is not only to define global public health as a global public good, but to design governance and financing systems capable of producing it equitably and reliably.

The contemporary global health architecture has achieved important gains, including expanded immunization, improved maternal and child survival, stronger disease control programs, and unprecedented scientific cooperation. However, those gains now coexist with a widening delivery gap. The COVID-19 pandemic, recurrent outbreaks, vaccine inequities, declining trust in institutions, and the underperformance of mechanisms such as COVAX have exposed structural weaknesses in coordination, accountability, financing, and legitimacy. These failures are not temporary disruptions; they reflect a fragmented system in which global commitments frequently fail to translate into local capacity and health outcomes.

This paper argues for a pragmatic reimagination of global public health governance. Rather than proposing a wholesale institutional reset, it advances a bottom-up and multi-level approach that bridges global, regional, national, and local architectures. The global level should retain stewardship functions: norm-setting, political legitimacy, coordination, standard-setting, and protection of equity principles. Regional mechanisms should be strengthened as operational bridges capable of translating global commitments into context-specific coordination, cross-border surveillance, pooled functions, and emergency response. National systems remain the foundation of delivery. Local and community actors, civil society, academia, and the private sector must be structurally included, not treated as peripheral implementers.

Maternal, newborn, and child health, including vaccination coverage and preventable mortality, offers a useful indicator of whether global public health goods are actually being delivered. These outcomes reveal whether financing, service delivery, trust, data, logistics, and governance are working together. High mortality, avoidable outbreaks, and declining immunization coverage should therefore be read not only as domestic health system problems, but as signals of failure in the global public health delivery chain.

The paper concludes with five actionable directions: define global public health goods functionally; create multi-level public health goods delivery compacts; strengthen regional public health institutions; align financing with public goods provision; and build accountability mechanisms that measure delivery, equity, and trust. The objective is to move from rhetorical solidarity toward operational solidarity: a system in which global public health is governed as a shared responsibility and delivered as sustained public value.

This paper was prepared by Fernando Ariel Garcia Terron, MD, MSc; Sandy Denis, MA; and Jorge Saavedra, MD, MSc, MPH, at the request of Club de Madrid, as part of the preparatory process for its 2026 Annual Policy Dialogue, Governing and Delivering Global Public Goods in a Fragmented World. It is intended to provide analytical input to the Dialogue's discussions on the governance and financing of global public goods, using global public health as a practical case study.

1. Introduction and Context

Framing global public health as a global public good offers a critical vantage point for assessing the effectiveness of contemporary governance structures in addressing transnational health challenges. As a public good, global public health is intended to promote health, prevent disease, reduce collective vulnerability, and ensure protection across borders. Its value is universal in principle: all populations benefit when outbreaks are detected early, when vaccines and medical countermeasures are available, when health systems are resilient, and when trusted institutions coordinate collective action. However, the functionality of global public health as a public good cannot be measured by aspiration alone. It must be assessed through outcomes, including who benefits, who is excluded, who decides, who pays, and whether commitments are translated into delivery.

Maternal, newborn, and child health provides a particularly sensitive lens for this assessment. According to existing estimates, the global maternal mortality ratio in 2023 was 197 per 100,000 live births, with more than 90 percent of maternal deaths occurring in low- and lower-middle-income countries, and Sub-Saharan Africa and Southern Asia accounting for approximately 87 percent of these deaths. Maternal and child survival, vaccination coverage, and the prevention of avoidable morbidity and mortality depend on a wide chain of public health functions: primary health care, health workforce capacity, reliable supply chains, community trust, data systems, financing, and emergency preparedness. When maternal and infant mortality remain high, or when vaccine-preventable diseases re-emerge, these outcomes reveal more than isolated domestic weaknesses. They expose how global, regional, and national systems fail to produce and deliver public health goods equitably.

Vaccination programs further illustrate this logic. Immunization is often delivered locally, but its enabling conditions are transnational: research and development, regulatory approval, procurement, cold chains, financing, public trust, surveillance of coverage and adverse events, and rapid response to outbreaks. Declining coverage and the re-emergence of vaccine-preventable diseases, therefore, signal a failure of the global public health delivery system, not only a failure of individual countries. These examples help ground the paper in a practical question: if global public health is a global public good, what governance and financing arrangements are needed to ensure that it is actually produced, accessed, and sustained?

Multilateralism has historically served as both the structural architecture and productive engine of the global health system. It has enabled states, intergovernmental organizations, civil society, philanthropic actors, academia, and the private sector to pool resources, expertise, norms, and political commitments. This architecture has produced consequential achievements: the consolidation of international sanitary cooperation into the World Health Organization, major advances in immunization and disease control, the creation of specialized initiatives such as UNAIDS, Gavi, the Global Fund, CEPI, and COVAX, and the emergence of regional bodies such as Africa CDC, the European CDC, CARPHA, and other regional or subregional mechanisms alongside influential convening platforms such as the G7, G20, BRICS, World Economic Forum. The fight against HIV is especially instructive because it generated unprecedented political mobilization, financing, and multi-stakeholder governance, demonstrating that disease-specific urgency can create institutional innovation when linked to clear mandates, measurable outcomes, and affected-community participation.

Yet the contemporary architecture is under stress. The COVID-19 pandemic exposed and intensified long-standing inequities in access to technologies, financing, manufacturing capacity, and decision-making power. It also revealed the limits of a model that depends heavily on voluntary cooperation, fragmented mandates, uneven donor priorities, and insufficient accountability. The repeated challenges observed during SARS, Ebola, and COVID-19 suggest a recurrent pattern: delayed response, weak compliance, incomplete information sharing, insufficient surge capacity, and uneven access to countermeasures.

These failures have contributed to a broader erosion of trust. Trust is not only a normative ideal; it is the invisible infrastructure that enables multilateral cooperation. When institutions fail to deliver timely assistance or equitable access, countries and citizens become less willing to rely on collective solutions. The result is a self-reinforcing cycle: low trust weakens cooperation, and weak cooperation further erodes trust. In global health, this cycle has encouraged national self-protection, vaccine nationalism, assertions of health sovereignty, and increasingly selective forms of cooperation.

Building on these challenges, this policy-oriented analytical paper advances a forward-looking inquiry into how global solidarity and equity can be strengthened through the reimagination of the global health architecture in response to evolving geopolitical, epidemiological, and institutional pressures. It calls for a bottom-up approach that is more integrative and coordinated; bridges global, regional, national, and local health architectures; promotes cross-regional exchange; and clarifies the agency and roles of actors involved in the creation, delivery, and receipt of global public goods. Central to this analysis are the gaps between high-level commitments and tangible implementation, particularly in low- and middle-income countries. The paper also interrogates financing structures, highlighting the need for increased domestic resource mobilization, more aligned and high-quality international financing, and regional financing mechanisms that enhance autonomy and responsiveness.

2. Conceptual Framework: Global Public Health as a Global Public Good

First, a conceptual clarification is necessary. The paper focuses on global public health, not global health in its broadest sense. Global health is commonly defined as an *area of study, research, and practice that prioritizes improving health and achieving equity for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care."* That definition is broad and valuable, but it includes both individual-level clinical care and population-level prevention. Global public health is narrower and more operational for the purposes of this paper. It refers to the collective functions, systems, norms, capacities, and interventions required to prevent disease, protect populations, reduce shared vulnerability, and enable equitable health outcomes across borders.

This distinction matters because not every health service is a global public good. Many health goods are rival or excludable in the strict economic sense: a hospital bed, a clinical consultation, or a medicine dose can be consumed by one person and denied to another. However, the systems that make public health possible - disease surveillance, epidemiological intelligence, regulatory standards, outbreak preparedness, pathogen sharing arrangements, health workforce capacity, trusted science, and equitable access mechanisms - have public good characteristics. Their benefits extend across borders, are difficult to confine to one population, and are often undersupplied when left to voluntary national action alone.

A strict economic definition based only on non-rivalry and non-excludability is therefore insufficient. Health illustrates the need for a broader but still precise definition of global public goods: goods, systems, functions, or enabling conditions whose provision produces shared cross-border benefits, whose underprovision generates collective risk, and whose equitable delivery requires cooperation beyond the capacity or incentives of any single state. Under this framing, global public health is both a normative commitment and a delivery challenge. It must be governed not only as a right or aspiration, but as a set of functions that require financing, institutional capacity, data, legitimacy, and accountability.

The global public health goods most relevant to this paper include: prevention through epidemiological surveillance and early warning systems; laboratory and genomic capacity; research, development and production for vaccines, diagnostics, therapeutics, and other medical countermeasures; regulatory norms and harmonization; health workforce and surge capacity; emergency stockpiles and supply chains; equitable access mechanisms for essential medicines and technologies; primary health care capacities that enable prevention and response; and global norms, standards, and legal frameworks.

These goods operate across different scales. Some functions, such as international standards, pathogen information sharing, and global equity norms, require global stewardship. Others, such as priority setting, cross-border outbreak response, pooled procurement, regulatory convergence, and shared surveillance platforms, may be more effectively coordinated regionally. Delivery, however, ultimately occurs nationally and locally. This means that the provision of global public health goods is inherently multi-level. A global agreement that does not improve local delivery is incomplete. A regional mechanism that does not strengthen national systems is insufficient. A national plan that cannot connect to regional and global systems is vulnerable.

The appropriate governance question is therefore not whether global, regional, or national levels should dominate. It is how functions should be assigned according to scale, capability, legitimacy, and delivery needs. Global institutions should articulate common goals, protect equity principles, set standards, convene political legitimacy, and coordinate across regions. Regional institutions and mechanisms should serve as the bridge between global commitments and regional realities, translating shared principles into priorities and operational responses that reflect epidemiological patterns, geographic proximity, and common public health needs. National governments should remain the primary duty-bearers for service delivery, regulation, and public investment. Local actors and communities should shape implementation, accountability, and trust. This principle of functional subsidiarity - form follows function - provides the conceptual foundation for the rest of the paper.

Maternal, newborn, and child health illustrates this multi-level chain. A safe birth and a vaccinated child depend on local services, national financing, trained workers, supply chains, community engagement, global research, regulatory approval, procurement, and international norms. The final outcome is local, but the production chain is global. For this reason, maternal and child mortality and vaccination coverage are not only indicators of domestic health system performance; they also indicate whether global public health goods are functioning.

3. Fragmentation as a Structural Challenge in the Global Public Health Architecture

The contemporary global health architecture can be understood as an interdependent system of global public health goods whose effectiveness depends on coherent investment and coordination. It is shaped by a proliferation of actors, mandates, financing channels, disease-specific initiatives, governance forums, and political interests that influence both the production and delivery of these goods. Surveillance infrastructures, laboratory networks, data systems, manufacturing capacity, preparedness and response mechanisms, primary health care, and risk communication function as mutually reinforcing components within this system. Fragmentation is not inherently negative; diversity can foster innovation, specialization, and resilience. Problems arise, however, when fragmentation leads to duplication, competition, gaps in delivery, weakened accountability, and misalignment with national and local priorities.

Fragmentation in global public health should be understood as a reflection of structural conditions that are reactive rather than proactively designed as intended. It emerges when a country with limited surveillance capacity cannot detect threats early; when regions lacking laboratory coordination are unable to interpret risks in a timely manner; and when a global system without equitable access to countermeasures fails to translate scientific innovation into effective protection. If any component is weak, the system is weakened. Fragmentation, therefore, is fundamentally becomes a failure of delivery across interconnected levels of the system.

Financing is a major driver of this fragmentation. Foreign assistance and vertical funding streams have often accelerated progress against specific diseases, but they have also shaped national expenditure patterns, reporting incentives, and implementation environments. Disease-specific programs can mobilize resources and technical excellence, as seen in HIV, malaria, TB, immunization, and pandemic response initiatives. However, when these streams are poorly aligned with domestic planning, they can

fragment health ministries, create parallel systems, and deprioritize investments in comprehensive public health capacity. A more coherent approach must recognize these overlaps and focus on aligning incentives so that countries are supported in investing in their own public goods—such as health systems, surveillance, and prevention—while also being able to effectively access and utilize external financing. Without this alignment, financing frameworks risk reinforcing fragmentation, rather than enabling coordinated and equitable provision of global public goods.

Fragmentation also manifests spatially. Countries in the Global South often face weaker fiscal space, limited manufacturing capacity, debt pressures, and dependence on donor-defined priorities. These conditions reduce their ability to participate as equal producers of global public health goods. Instead, they may be positioned primarily as recipients of assistance or sites of implementation. This reinforces asymmetries in agenda-setting, knowledge production, regulatory authority, and access to technologies. The result is a global architecture in which the benefits of public health goods are proclaimed as universal, but the capacity to produce and govern them remains unevenly distributed.

Trust and authority are also fragmented. Global health governance relies heavily on voluntary cooperation and non-binding standards. This model can work when actors trust each other, when incentives are aligned, and when compliance is visible. However, when crises emerge, states often prioritize domestic political survival and national control. During COVID-19, vaccine nationalism, export restrictions, supply concentration, and inequitable access to countermeasures intensified mistrust and weakened confidence in multilateral mechanisms.

Data governance illustrates the operational consequences. Effective global public health depends on timely, accurate, standardized, and trusted data. Yet countries may be reluctant to share information if they fear economic penalties, travel restrictions, stigma, or lack of reciprocal benefit. Communities may distrust surveillance if they do not see services or protection follow. Research findings may not translate into policy when institutions lack legitimacy or when information ecosystems are contested. The governance of data must therefore be linked to trust, incentives, and equity, not treated as a purely technical matter.

At the regional level, fragmentation appears in the form of ad hoc partnerships and uneven institutionalization. Some regions have developed stronger public health bodies, while others rely on fragmented subregional arrangements or episodic cooperation. Regional institutions can reduce coordination complexity, build trust among countries with shared epidemiological and political contexts, and support cross-border action. But regionalism can also reproduce exclusion if weaker states, civil society, academia, the private sector, and other non- traditional stakeholders are not included, or if regional mechanisms lack financing and clear mandates. The challenge is not to replace global governance with regional governance, but to connect them more effectively.

The governance challenge, then, is to intentionally connect fragmented components into a coherent ecosystem. A more effective architecture must manage fragmentation rather than pretend it can be eliminated. It must clarify roles, reduce duplication, align financing, strengthen regional bridges, and create accountability and trust for delivery. This is the bridge between concept and policy: global public health can only function as a global public good if the architecture that produces it is interoperable, legitimate, and resilient.

4. Tensions Between National Priorities and Global Priorities

The failure to coordinate global public health goods is rooted in a fundamental tension: health risks are transnational, but political authority, fiscal responsibility, and accountability remain largely national.

Governments are expected to protect their populations, justify public spending to domestic constituencies, and respond to immediate political pressures. Yet infectious disease threats, supply chains, scientific knowledge, migration, climate-related risks, and financing flows do not respect borders. This mismatch between national political incentives and global public health needs is one of the defining governance challenges of the current moment.

4.1 Power asymmetries between the Global North and the Global South

At the global level, tensions are most visible in the divide between countries with greater financing power, technological capacity, manufacturing infrastructure, and influence over rule-setting, and countries that depend more heavily on external financing, imported technologies, and decisions taken elsewhere. These asymmetries shape negotiations on intellectual property, pathogen access, benefit sharing, regulatory standards, manufacturing, and burden-sharing. They also affect which risks are prioritized, which data are used, which institutions are trusted, and which populations receive access first.

The Pandemic Agreement and discussions on pathogen access and benefit-sharing (PABS annex) illustrate these tensions. Countries in the Global South have pushed for stronger equity guarantees, predictable access to countermeasures, technology transfer, and capacity building. Countries with stronger innovation ecosystems and pharmaceutical industries have often emphasized intellectual property protection, voluntary mechanisms, and national sovereignty over industrial policy. The result is slower consensus, higher negotiation complexity, and a persistent gap between commitments to equity and the mechanisms required to deliver it.

These tensions should not be reduced to a simple opposition between sovereignty and multilateralism. Sovereignty can be a legitimate demand for greater domestic and regional capacity. The problem arises when sovereignty becomes a substitute for cooperation, or when multilateralism is perceived as a vehicle for unequal rules. A reimagined architecture must therefore reconcile sovereignty and solidarity: countries should have a stronger capacity to protect their populations, while participating in shared arrangements that reduce collective risk.

4.2 National-level pressures and constraints

Inside countries, global public health commitments compete with fiscal and political realities. Many low- and middle-income countries face constrained fiscal space, debt servicing pressures, competing demands from education, infrastructure, security, and social protection, and reliance on external funding. Health ministries are often responsible for implementing global commitments without adequate authority over financing, procurement, workforce, or cross-sectoral determinants. This weakens the translation of global norms into domestic capacity.

In such contexts, governments may prioritize short-term service continuity over long-term preparedness, emergency response over prevention, and visible clinical services over less visible public health infrastructure. The consequences are measurable. Maternal and child mortality, declining immunization coverage, and preventable outbreaks reveal whether systems are able to sustain essential public health functions. These indicators are useful because they sit at the intersection of financing, service delivery, governance, trust, and equity. A high maternal mortality ratio or the resurgence of a vaccine-preventable disease should therefore be treated as a signal of system failure across levels, not only as a domestic policy problem. This requires recognizing locally generated signals as central to evaluation, ensuring that bottom-up insight guides action and triggers timely and sustainable support.

External assistance can help, but when it is unpredictable or fragmented, it can also deepen vulnerability. Unstable aid flows, donor retrenchment, and vertical reporting requirements undermine planning and sustainability. Conversely, high-quality international financing should strengthen domestic public health capacities, align with national priorities, reduce duplication, and build institutions that remain functional beyond project cycles. Financing must be judged not only by volume, but by whether it produces durable public goods.

4.3 The shift toward regional and bilateral cooperation

As trust in universal multilateral arrangements weakens, countries increasingly seek alternative or complementary forms of cooperation. Bilateral agreements may offer speed, political alignment, or access to specific resources, but they can also reinforce asymmetry and competition. Regional cooperation offers a more promising middle layer. It can reduce coordination complexity, build on shared epidemiological risks, support pooled capacities, and create platforms for trust among countries with closer geographic, cultural, linguistic, or institutional ties. Its significance lies in its capacity to operationalize the production and delivery of global public goods at a regional scale in ways that are more timely, efficient, and contextually embedded. By aligning shared needs with geographic proximity and relational trust, regional arrangements enhance responsiveness while reinforcing coordination and mutual accountability across states.

Africa CDC demonstrates how regional public health institutions can strengthen surveillance, emergency response, workforce capacity, and continental health autonomy. Southeast Asian cooperation through ASEAN-related health frameworks such as the recently established ASEAN Centre for Public Health Emergencies and Emerging Diseases (ACPHEED) illustrates how regional preparedness and policy coordination can be anchored in existing political structures. In Latin America and the Caribbean, the Caribbean Public Health Agency (CARPHA), the Council of Ministers of Health of Central America and the Dominican Republic (COMISCA), the Andean Health Organization – Hipólito Unanue Agreement (ORAS-CONHU), the MERCOSUR health mechanisms, and other regional or subregional platforms provide foundations, but uneven capacity and fragmented political integration show the need for stronger, more operational regional coordination. The point is not to create parallel systems for their own sake. It is to ensure that regional bodies can act as bridges between global commitments and national implementation.

Regionalism should therefore be understood as an adaptive response to fragmentation, not a replacement for global governance. Global public health requires a unifying conceptual framework and global stewardship. But the coordination and delivery of many public health goods can be regional. This layered approach aligns with the idea that governance should follow the nature of the good: some functions are global, some are regional, and all must ultimately improve delivery at the country and the community level.

5. Innovative and Actionable Policy Options

The following policy options are designed for a complex geopolitical environment in which trust is uneven, institutional reset is unlikely, and delivery must improve rapidly. They aim to combine a bold long-term vision with practical steps that can be implemented through existing or adapted institutions.

5.1 Adopt a functional definition of global public health goods

Club de Madrid and partners should promote a functional definition of global public health goods that distinguishes between individual health services and the public health systems that protect populations. The definition should identify the functions that generate shared cross-border benefits: surveillance, early warning, data systems, laboratory networks, research and development, regulatory standards, countermeasure access, emergency coordination, health workforce capacity, and trusted science. This would reduce conceptual ambiguity and help policymakers identify what should be financed, governed, and measured as a public good.

- Policy action: Develop a concise taxonomy of global public health goods, distinguishing global stewardship functions, regional coordination functions, and national/local delivery functions.
- Policy action: Use vaccination coverage, preventable outbreak indicators, and maternal and child mortality as practical tests of whether global public health goods are reaching people.

5.2 Create multi-level public health goods delivery compacts

A major weakness of the current system is the gap between high-level commitments and implementation. To address this, countries, regional bodies, global institutions, civil society, academia, and financing partners could establish multi-level compacts for the delivery of public health goods. These would not be new organizations, but structured agreements that define roles, targets, financing commitments, data-sharing protocols, and accountability mechanisms for specific public health goods.

- Policy action: Pilot compacts for priority functions such as cross-border surveillance, vaccine delivery readiness, maternal and child health resilience, and emergency workforce surge capacity.
- Policy action: Require each compact to specify who provides political stewardship, who coordinates regionally, who implements nationally, who represents communities, and how progress is verified.

5.3 Strengthen regional public health institutions as operational bridges

Regional institutions should be strengthened as providers of public health goods or as coordinators, especially for pandemic prevention, preparedness, and response; epidemiologic surveillance; regulatory convergence; pooled procurement; emergency response; and peer learning. This does not mean transferring global responsibility downward. It means recognizing that many public health goods are best coordinated at the regional level because countries share borders, disease profiles, mobility patterns, supply chains, and political forums.

- Policy action: Support regional surveillance and early warning platforms with interoperable data standards and clear benefit-sharing arrangements.
- Policy action: Create or strengthen regional rapid response rosters, laboratory networks, and procurement mechanisms that can be activated before outbreaks escalate.
- Policy action: Encourage cross-regional exchange among Africa CDC, CARPHA, ECDC, Gulf CDC, SECID, ACPHEED, and other regional bodies to share lessons on governance, financing, and delivery.

5.4 Align financing with public goods provision and institutional resilience

Financing determines whether governance arrangements can deliver. The current model often funds projects, emergencies, or diseases rather than public goods functions. A reimagined financing approach should combine increased domestic resource mobilization, predictable international financing, and regional mechanisms that support autonomy and resilience. Financing should be assessed by whether it strengthens durable capacities, not only by whether it disburses resources.

- Policy action: Shift financing from short-term emergency response toward anticipatory investment in surveillance, laboratories, workforce, data systems, and primary health care capacities.
- Policy action: Explore regional public health financing mechanisms, including pooled funds, debt service suspension, and catalytic financing through multilateral development banks.
- Policy action: Decouple decision-making voice from financial contribution alone. Financing power should not automatically translate into agenda-setting dominance.

5.5 Institutionalize multi-stakeholder governance and accountability

States remain central, but states alone cannot deliver global public health goods. Civil society, communities, local governments, academia, frontline institutions, and the private sector are all involved in producing, delivering, and receiving public health goods. Governance models should therefore be more inclusive and distributed, including affected communities, implementers, and other non-traditional stakeholders, structurally rather than only consultatively. The governance model of the Global Fund offers one example of how governments, civil society, and other actors can be incorporated into decision-making differently from purely member-state models.

- Policy action: Require public health goods mechanisms to include structured representation from governments, civil society, technical institutions, and communities affected by implementation.
- Policy action: Build accountability frameworks that measure equity, delivery, institutional performance, and trust, not only financial disbursement or activity completion.
- Policy action: Create periodic exchanges among public health goods providers to reduce duplication, share lessons, and align standards.

5.6 Build a two-tier model for legitimacy and delivery

Building on emerging debates around "two-speed multilateralism," particularly the COP30 Presidency's proposal to preserve the legitimacy of consensus-based global frameworks while enabling faster implementation through flexible coalitions and task-oriented actors, a useful governance pathway is a two-tier model.

The first tier is a consensus-based global framework that provides legitimacy, norms, equity principles, and shared goals. The second tier is a flexible implementation layer composed of regional organizations, coalitions of willing countries, task-oriented public goods providers, development banks, civil society, academia, and technical agencies. The first tier protects coherence and legitimacy; the second tier delivers action. The key is coordination across tiers so that flexible implementation accelerates delivery without fragmentation.

- Policy action: Use global institutions to set principles and standards, while empowering regional and task-oriented mechanisms to implement context-specific solutions.
- Policy action: Establish transparency requirements for coalitions of the willing so they complement rather than bypass multilateral commitments.

6. Forward-Looking Recommendations

Recommendation 1: Reframe global public health as a system of public goods functions. Policymakers should move beyond broad declarations that health is a global public good and identify the specific functions that must be produced and sustained: surveillance, data, laboratories, workforce, countermeasures, regulatory capacity, preparedness, financing, and trust. This makes the concept operational and measurable.

Recommendation 2: Use outbreak detection and response and vaccination outcomes as indicators of delivery, immunization coverage, and preventable outbreaks should be used as sensitive indicators of whether global public health goods are reaching populations. These outcomes reveal whether public goods are being translated into local services, equity, and protection.

Recommendation 3: Strengthen regional architectures without abandoning global stewardship. Regional institutions should be empowered to coordinate public health goods where proximity matters, particularly surveillance, emergency response, regulatory harmonization, and pooled capacities. Global institutions should focus on norms, standards, legitimacy, coordination, and equity guarantees.

Recommendation 4: Align financing with long-term public health capacity. Financing should prioritize durable capacities rather than episodic crisis response. Development banks, global health funds, bilateral donors, and domestic budgets should align around public goods functions and reduce fragmentation. Predictability, autonomy, and resilience should be treated as financing goals.

Recommendation 5: Rebuild trust through accountability and inclusion. Trust cannot be restored through rhetoric alone. Governance mechanisms must be diverse and inclusive, including academia, affected communities, civil society, local governments, technical institutions, the private sector, and implementers. Accountability should measure whether public goods are delivered, whether benefits are equitable, and whether institutions respond to local realities.

Recommendation 6: Promote cross-regional learning. Regions are experimenting with different models of public health governance. A structured platform for cross-regional exchange could allow regional bodies and mechanisms to compare approaches, identify transferable practices, and support emerging regional initiatives.

Recommendation 7: Protect global public health goods from political volatility. Public goods providers need governance and financing models that are resilient to opt-outs, donor retrenchment, and political cycles. Options include broader stakeholder participation, diversified financing, capitalized regional mechanisms, contingency financing, and clear rules for emergency activation.

7. Conclusion

Global public health is a global public good, but it will not function as one unless the architecture that produces it is redesigned for delivery, equity, and trust. The central challenge is not only technical; it is political and institutional. Power asymmetries, fragmented financing, weak accountability, and declining trust have created a delivery gap between global commitments and local outcomes. Declining vaccination coverage, preventable outbreaks, and child mortality are visible reminders that the promise of global public health has not been equitably realized.

A more effective architecture should be bottom-up, multi-level, and functionally differentiated. It should preserve global stewardship while strengthening regional coordination and national and local implementation. It should treat civil society, academia, local governments, communities, and the private sector as structural actors in governance, not peripheral participants. It should align financing with durable public goods functions rather than short-term projects. Above all, it should move from rhetorical solidarity to operational solidarity: the practical capacity to produce, finance, deliver, and account for global public health as sustained public value.

The objective is not to replace the current system with an unrealistic new order. It is to reimagine and upgrade it so that it can work in a fragmented world. Fragmentation may be a structural feature of the current geopolitical context, but it need not produce paralysis. If connected through clear functions, regional bridges, inclusive governance, resilient financing, and measurable accountability, a fragmented landscape can become a more adaptive ecosystem for delivering global public health as a global public good.

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